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**Experiences of mental health professionals:
Patient suicide and working in a Crisis Team.**

**By
Helena Young**

A thesis submitted in partial fulfilment of the requirements for the
degree of Doctor of Clinical Psychology

Coventry University, Faculty of Health & Life Sciences
University of Warwick, Department of Psychology

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List of abbreviations

AO	Assertive Outreach
CMHT	Community Mental Health Team
CRHT	Crisis Resolution Home Treatment
DOH	Department of Health
IES	Impact of Events Scale
IPA	Interpretative Phenomenological Analysis
NHS	National Health Service
UK	United Kingdom
WHO	World Health Organisation

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Declaration

This thesis was carried out under the supervision of Dr. Adrian Neal (Clinical Psychologist) and Dr. Michelle Webster (Clinical Psychologist). This thesis has not been submitted for a degree at another university and is the named author's own work. This thesis has been prepared for submission to the following journals. Any deviation from the journal word limits was for the purpose of thesis submission to aid overall cohesion and will be amended for journal publication.

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(see appendix A for instructions for authors)

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Chapter two has been broadly prepared for - Social Science & Medicine
(see appendix B for instructions to authors)

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Summary

This research thesis explores mental health professionals' reactions to patient suicide and the emotional experiences of working in a Crisis Team.

Chapter one is a literature review examining twelve empirical studies of the impact of patient suicide on mental health professionals and the resources they draw on to cope with the effects. The review revealed a range of personal and professional responses amongst professionals and highlighted the concept of blame in the coping process.

Chapter two is a qualitative empirical study of seven clinicians' emotional experiences of working in a UK Crisis Team. Interpretative Phenomenological Analysis revealed three main themes of importance; response to difficult emotions, impact on self and intergroup processes. The clinical implications and areas for future research are discussed alongside methodological considerations and limitations.

Chapter three is a reflective account of the emotional experience of conducting the research and considers the impact of the chosen methodology, parallels of experience between the researcher and the participants and the impact of the research process on future clinical practice.

Chapter 1: Literature Review

Personal and professional reactions of mental health professionals to patient suicide: A systematic review of the literature.

1.1 Abstract

Almost one million people worldwide die from suicide each year, with mental illness being a major risk factor (World Health Organisation, WHO, 2012).

Although there is a wealth of information on suicide, there is a limited amount of research on the impact of patient suicide on mental health professionals and the resources they need to cope with its effects (Pallin, 2004). Support for clinicians following patient suicide is important for the clinician's well-being and ongoing patient care. The present review critically examines the existing empirical research on the personal and professional reactions of mental health workers to patient suicide and the resources that they draw on to cope with these reactions. The review revealed a variety of emotional responses commonly associated with grief and professional reactions which included changes to practice. It was found that issues of blame and responsibility appear to impede the coping process, thus it is recommended that healthcare providers acknowledge and manage these issues sensitively.

Key words: suicide, psychiatric staff, coping, emotion, reactions, professional practice.

1.2 Introduction

Suicide is a global problem. Approximately one million people worldwide take their own life each year (WHO, 2012), with as many as 5,608 people reported to have died by suicide in the United Kingdom (UK) in 2010 (Office for national Statistics, 2012). Mental illness increases the risk of suicide, making people under the care of mental health services a high risk group. It is reported that in England around 1200 suicides per year are committed by patients in the care of mental health services (Department of Health, DOH, 2011).

Although the National Suicide Prevention Strategy (DOH, 2002) outlines several target areas to reduce the risk of suicide, it does not take into account the impact of suicide on mental health professionals. One proposed 'area for action' in the new National Suicide Prevention Strategy which is due for publication this year (2012), is to provide better information and support to those bereaved or affected by a suicide. The proposed support and recommended resources are mainly directed towards families bereaved by suicide and include details on how healthcare professionals can help them. The consultation document for this new strategy does, however, acknowledge that people, who come into contact with suicide because of their work, including National Health Service (NHS) workers and healthcare professionals, will be affected by a patient suicide in some way. There are,

however, no suggested resources that are specifically tailored to the needs of staff.

Research suggests that organisational change can increase the risk of patient suicide (Pirkola, Sund, Sailes, & Wahlbeck, 2009). Organisational change has also been associated with demoralisation in the mental health workforce, which may undermine patient care (Hawton & Saunders, 2009). Therefore, patient safety and the work experiences of clinicians are particularly pertinent in the current climate of organisational change within the NHS.

1.2.2 Existing Literature on mental health professionals' reactions to patient suicide

Although a large amount of research has been conducted on suicide, there is a lack of information on how it impacts on professionals and the resources they need to cope with its effects (Pallin, 2004). The literature does suggest that patient suicide can have a similar traumatic effect on clinicians (Cryan, Kelly & McCaffrey, 1995) to that of relatives, with both experiencing shock, grief, guilt and anger following patient suicide (Hendin, Pollinger Hass, Maltsberger, Szanto, & Rabinowicz, 2004). In addition, clinicians also experience the effects of suicide in relation to their professional role. It has been suggested that patient suicide is an 'occupational hazard' (Chemtob,

Bauer, Hamada, Pelowski & Muraoka, 1989) for mental health professionals, with most mental health workers losing a patient to suicide during at some point in their career (Foley & Kelly, 2007). Although the need for support following patient suicide has been acknowledged (DOH, 2011), support services for psychiatric staff are minimal (Bohan & Doyle, 2008).

Three existing articles were found in the literature that review mental health professional's responses to patient suicide. Two of these articles (Collins, 2003 & Farberow, 2005) are unsystematic in nature, offering summaries of the literature and include anecdotal evidence. Although anecdotal evidence can be of value, there are problems in terms of reliability, validity and generalisability. The third article (Beautrais, 2004) is a literature review which aims to uncover grief reactions after suicide and highlight support that would be helpful to people bereaved by suicide. It has a focus on families, but also considers the reactions of, and support for, therapists, doctors and professionals. It offers a brief summary of reactions found in three studies relating to professionals and suggests some recommendations for support. Although more comprehensive than the other two reviews, this article fails to critique the evidence on the reactions of mental health professionals to patient suicide. This brings into question the quality of the evidence that the recommendations are based on.

1.2.3 Rationale for current review

A systematic critical review of the literature on the reactions and coping behaviours of mental health workers who have experienced patient suicide will provide an overview of the empirical evidence in this area. It is hoped that the resulting information about the personal and professional needs of staff can be used to develop support systems to promote staff well-being following patient suicide. The promotion of staff well-being following patient suicide is likely to have a positive impact on continued patient care.

1.3 Search Strategy

Four electronic databases (Academic Search Complete, CINAHL, Medline and PsycINFO) were searched through the EBSCO electronic database provider between November 2011 and January 2012. These databases were chosen for their relevance to different aspects of health and the large number of journals they access. Search terms were selected based on review objectives.

Keyword searches specified the incident ('suicide'), the effects ('emotion*' or 'response' or 'reaction' or 'experience' or 'impact' or 'coping') and the professional group ('social workers' or 'occupational therap*' or 'psychiatrist' or 'mental health practitioner' or 'mental health professional' or 'mental health worker' or 'mental health personnel' or 'clinical psychologist' or 'psychiatric nurse' or 'therapist'). The terms were used to search the titles, abstracts and

subject headings of the articles within the databases. Searches were limited to papers from peer-reviewed journals only.

1.3.1 Inclusion and exclusion criteria

Searches revealed 1990 results and were considered for inclusion if they were specific to suicide, empirical in nature, based on samples of qualified mental health professionals, included data from the professionals' perspective and were written in the English language. These criteria were used to manually sort through papers. Figure 1 provides details of the selection process and gives reasons for the exclusion of articles.

Identification

Records identified through
database searching:
(n = 1990)

Records excluded through
title inspection:
(n = 1928)

Screening

Abstracts screened
(n = 62)

Records excluded
(n = 25)

Eligibility

Full text articles assessed
for eligibility (n = 37)

**Full text articles excluded
(n = 28)**

Not relevant to review (n = 8)

Non-empirical (n = 4)

Includes suicide attempts
(n = 5)

Includes unqualified
clinicians (n = 10)

Non-English language (n = 1)

Relevance

Relevant articles (n = 9)

Articles found through:
- Reference searches
(n = 2)
- Citation searches
(n = 1)

Included

Studies included in the systematic review
(n = 12)

Figure 1: Flow diagram of inclusion and exclusion criteria

1.4 Results

In total twelve articles were included in the review. The main features and findings of these papers are summarised in Table 1.

Table 1: Summary of papers included in the review

Author	Sample	Method / Data Collection	Findings
Alexander et al. (2000)	159 Psychiatrists Gender, age and years of practice of those included not specified. Scotland	Postal Survey Author devised questionnaire	33% reported being affected personally by the patient suicide – including low mood, poor sleep, irritability, decreased confidence, pre-occupation and less ability to deal with own family problems. 42% reported changes to professional practice following patient suicide – including increased risk awareness and suicide observations. Colleagues and family were identified as the most helpful source of support.
Chemtob et al. (1988a)	131 Psychiatrists 85% Male Mean age 50.9 Mean years of practice 19.3 US	Postal Survey Author devised questionnaire scale and the Impact of Events Scale (IES) (Horowitz et al, 1979).	Personal impact included moderate levels of guilt, anger, intrusive thoughts, loss of self esteem and emotional numbness. Professional impact included increased focus on suicide clues and improved record keeping. Psychiatrists also increased their use of colleague and peer consultation following patient suicide. 53% of psychiatrists had IES scores comparable to a clinical group who had recently experienced the death of a parent.
Chemtob et al. (1988b)	81 Psychologists 73% Male Mean age 50 Mean years in practice 18.5 US	Postal Survey Author devised questionnaire scale and the Impact of Events Scale (IES) (Horowitz et al, 1979).	Personal impact included moderate levels of guilt, anger, intrusive thoughts, loss of self esteem and emotional numbness. Professional impact included increased focus on suicide clues and improved record keeping. Psychologists also increased their use of colleague and peer consultation following patient suicide. 49% of psychologists had IES scores comparable to a clinical group who had recently experienced the death of a parent.

Darden & Rutter (2011)	<p>6 Clinical Psychologists</p> <p>4 Males, 2 Females</p> <p>Age 39-53</p> <p>Qualified 10-17 years</p> <p>US</p>	<p>Qualitative semi-structured interviews</p> <p>Analysis: Consensual Qualitative Research Guidelines (Hill et al., 1997).</p>	<p>All participants experienced shock as their initial reaction. Professional reactions included hypersensitivity to risk, with half the participants reviewing their clinical decisions. All participants reported that support from colleagues' facilitated recovery.</p>
Grad et al. (1997)	<p>63 Clinicians including: 47 Psychiatrists 10 Psychologists 6 did not specify</p> <p>27 Male, 36 Female</p> <p>Mean age 44</p> <p>Means years of practice 16</p> <p>Slovenia</p>	<p>Postal Survey</p> <p>Author devised questionnaire</p>	<p>Guilt was reported to be the most common personal reaction and increased caution in the treatment of patients was a common professional reaction. Coping involved increased conferring with colleagues, partners and supervisors.</p> <p>Significant gender differences were found, with females reporting shame and guilt, seeking consolation and having doubts about their own professional knowledge more than males.</p>
Kelleher & Campbell (2011)	<p>40 Psychiatrists</p> <p>Gender of those included not specified.</p> <p>Age not specified</p> <p>Mean years in practice 20.5</p> <p>Republic of Ireland</p>	<p>Postal Survey</p> <p>Questionnaire (from Alexander et al. (2000) study).</p>	<p>Personal sadness, low mood and self-doubt were commonly reported. Professional changes included a sense of helplessness and anxiety making treatment decisions, a reluctance to discharge patients and increased risk awareness. Psychiatrists reported that their own families (85%) and peers (73%) were helpful in the coping process, with mixed feelings about team meetings.</p>

Landers et al. (2010)	<p>143 Consultant Psychiatrists</p> <p>79 Male, 64 Female</p> <p>56% age 40-49</p> <p>Qualified 10-20 yrs</p> <p>Ireland</p>	<p>Postal Survey</p> <p>Author devised questionnaire</p>	<p>Disturbances to personal lives included a pre-occupation with the suicide (87-97%), guilt (69-82%), disturbed sleep (27-42%) and low mood (31-36%). Changes to professional life included increased risk awareness (52-87%) and decreased confidence (52-68%). Support from colleagues (95-97%) and friends and family (66-80%) were reported to be most helpful.</p>
Linke et al. (2002)	<p>44 Clinicians including:</p> <p>18 Psychiatric Nurses</p> <p>15 Social Workers</p> <p>2 Psychiatrists</p> <p>4 Clinical Psychologists</p> <p>2 Occupational therapists</p> <p>2 Managers</p> <p>1 Administrator</p> <p>14 Male, 28 female, 2 unrecorded</p> <p>Mean years qualified 12.9</p> <p>UK</p>	<p>Postal Survey</p> <p>Questionnaire (adapted from Alexander et al. 2000 study).</p>	<p>76% of the sample reported that a patient suicide had a personal impact including grief. 84% of the sample reported that a patient suicide had a professional impact which included anxiety and avoiding clients at work who were perceived as at risk. Most common source of support was talking to colleagues.</p>
Sanders et al. (2005)	<p>145 Social Workers</p> <p>39 Male, 106 Female</p> <p>Age 25 – 66</p> <p>Mean Yrs in practice 19</p> <p>US</p>	<p>Qualitative - Postal Survey</p> <p>Two open-ended questions, as part of a larger quantitative study.</p>	<p>Themes relating to personal reactions immediately following suicide included: Sadness, trauma, shock, anger, self-blame, fears and feelings of professional failure. Themes relating to suicide at the time of the survey included: Continued emotional reactions, reconciliation, power and control issues and changes to practice.</p>

Talseth & Gilje (2007)	<p>5 Psychiatrists</p> <p>4 Males, 1 Female</p> <p>Age 41- 49</p> <p>Years of practice 5-12 years</p> <p>Norway</p>	<p>Qualitative descriptive study</p> <p>Interviews</p> <p>Analysis: Thematic analysis</p>	The authors report the main theme as 'Unburdening grief' which manifested through psychiatrists shifting their perspectives. Six sub-themes describe the process from grief to consolation. Important findings were that ethical reflection on the self and others and talking to others facilitated coping.
Thomygangkoon & Leenars (2008)	<p>94 Psychiatrists</p> <p>65 Male, 29 Female</p> <p>Age 25 – 79</p> <p>Years of practice not specified</p> <p>Thailand</p>	<p>Postal Survey</p> <p>Questionnaire based on 'clinician suicide survivor survey' (American Association of Suicidology).</p>	Sadness and guilt reported to be the most difficult emotional reactions. Low numbers of participants doubted their competence or feared litigation. Psychiatrists in this study persistently reviewed their actions. Talking to colleagues was reported as most helpful.
Ting et al. (2006)	<p>25 Social Workers</p> <p>4 Male, 21 Female</p> <p>Age 37-69</p> <p>Years in Practice 9 – 34</p> <p>US</p>	<p>Qualitative semi-structured telephone interviews</p> <p>Analysis: Constant Comparative method</p>	Themes relating to personal reactions included denial, grief, anger, guilt, isolation, avoidance, intrusions, responsibility. Themes relating to the professional impact included feelings of incompetence and changes to professional practice such as increased awareness of risk. Social workers attempted to cope through justifying their actions and accepting the patient suicide.

1.4.1 Aims of the Review

The current review aims to critically examine the evidence base on the reactions of mental health professionals to patient suicide. As clinicians are both professionals and human beings they are likely to experience reactions to patient suicide on a personal and a professional level. Although most of the papers within the present review deal with the issue of personal and professional impact separately, the concepts are difficult to differentiate as there is some overlap. With this in mind the current review will attempt to answer three main questions:

- What is the personal impact of patient suicide on mental health professionals?
- What is the professional impact of patient suicide on mental health professionals?
- How do mental health professionals cope in the aftermath of a patient suicide?

1.4.2 Personal Impact

Many of the personal reactions described by these studies are similar to the common grief responses to death found in the literature (Bonanno & Kaltman, 2001).

1.4.2.1 Shock /Denial

Five studies within this review reported that mental health professionals experience shock and denial in relation to patient suicide. Two qualitative studies of social workers reported surprise and shock reactions, denial of patient intent, denial of death by suicide and denial that suicides can happen (Ting, Sanders, Jacobson, & Power, 2006, Sanders, Jacobson, & Ting, 2005). The results of the two studies may be limited by their insufficient sampling strategies. Both studies draw their samples from the same larger quantitative study (Jacobson, Ting, Sanders & Harrington, 2004). Ting et al (2006) conducted a separate study on a sub-sample of participants from the original study, but due to anonymity was unable to compare characteristics of those who did and did not take part. Sanders et al. (2005) based their study on two open-ended questions as part of the larger survey, limiting the space to record additional reactions to client suicide. Although the original sample was randomly selected, it was also unable to compare responders and non-responders, throwing the representative nature of these samples into question.

All six clinical psychologists in a qualitative study identified shock and /or surprise as their initial reaction, with two psychologists reporting denial in that they thought the identity of the patient who had committed suicide had been mistaken (Darden and Rutter, 2011). Shock was also reported in a qualitative study of psychiatrists (Talseth and Gijle, 2007). Although

qualitative methodology is able to explore the nature of experience, the small samples used mean it is difficult to establish the size of the phenomenon.

In a questionnaire survey of psychiatrists (Thomyangkoon & Leenars, 2008), of the 82% who responded to an open question, 13% reported feelings of shock. Of the 94% of participants who responded to a closed question in the same survey, a similar amount (13.6%) identified having difficulty believing the death was a suicide, with only 2.3% identifying the reaction as strong. Although these results suggest that only a small proportion of psychiatrists reported experiencing shock or disbelief following patient suicide, this should be considered with caution due to the lack of a complete data set.

Other studies within the review do not report feelings of shock or disbelief in their findings and it is possible that this is because they do not specifically ask about it. These results suggest that although clinicians experience shock and denial in relation to patient suicide, it is not the reaction that affects them the most.

1.4.2.2 Sadness and Grief

Emotions relating to sadness were reported by seven of the studies within this review and included feelings of grief, loss and depression. 'Grief and Loss' was one of the themes that emerged from a qualitative study of social workers (Ting et al., 2006). In this study participants described experiencing

a sense of loss, sadness, disappointment and the recurrence of feelings from previous losses in their personal life, following patient suicide. 'Sadness and depression' was also reported in a separate study of social workers (Sanders et al., 2005). Here these feelings related to the actual death of the client, the client's inability to find a reason to live, the lack of seriousness given to the suicide threat by the organisation, the undesired outcome following clinician's efforts, a loss of innocence about the world and feeling a personal loss. The authors of this study reported no real change in emotional reactions of social workers over time. However, this claim is not based on statistical analysis and contrasts with findings from other studies within this review (Chemtob, Hamada, Bauer, Kinney, & Torigoe, 1988a, Chemtob, Hamada, Bauer, Kinney, & Torigoe, 1988b).

The feelings of sadness appear to impact on professionals personally, as reported by one study of psychiatrists (Kelleher and Campbell, 2011). Similarly, in a study of psychiatrists and clinical psychologists, 43% of the sample responded affirmatively to the yes-no item asking them if they had experienced 'Grief as after a personal loss' (Grad, Zavasnik, & Groleger, 1997). Grief was also reported as the most common response to an open question in this study about feelings experienced initially, and in the days following patient suicide. The authors do not provide any information about the participants who did not respond to the survey, which brings the

representative nature of the sample into question. Furthermore the authors provided no information on how the questionnaire they used was developed.

'Sadness/depression/hopelessness' was reported to be one of the highest ranked items in a study of psychiatrists (Thomyangkoon & Leenaars, 2008). Sixty-two percent identified medium to strong difficulties in this area. Of the 82% who responded to an open question about the impact of suicide, 31% identified elements of sadness.

Feelings of grief and sadness were also reported by Linke, Wojciak, and Day (2002), in their study of community mental health professionals. Although their study reported that patient suicide had a personal impact on 76% (n = 29) of the sample, it is difficult to know from this study the wider extent to which grief and sadness may have been experienced due to missing information, which the authors offer no explanation for.

The process of moving from grief to consolation was the focus of a qualitative study of psychiatrists (Talseth & Gilje, 2007) and will be discussed further in the recovery and coping section of this review. Overall, sadness as a personal reaction to patient suicide seems to be apparent across the disciplines, with some studies reporting medium to high rates.

1.4.2.3 Low mood

In relation to sadness, low mood was also reported by three studies of psychiatrists. Alexander, Klein, Gray, Dewar, & Eagles (2000) developed a questionnaire to identify the effects of patient suicide on psychiatrists. The questionnaire was based on a review of the literature, consultation with colleagues and a pilot study. This procedure increases the questionnaire's content validity. The measure has been used by two studies within this review to examine the effects of patient suicide on psychiatrists (Alexander et al., 2000 & Kelleher & Campbell, 2011). Psychiatrists in these studies were asked to respond to an open question about the aspects of their personal life most adversely affected by a patient suicide. Low mood was found amongst the most common responses in both studies, however the authors do not specifically report how common. Asking only about adverse effects leaves no room for participants to report experiences following patient suicide that were not adverse, which may fail to capture the true range of experience.

Psychiatrists in another study were asked whether they had experienced low mood in response to a) their most recent and b) their most distressing suicide (Landers, O'Brien & Phelan, 2010). Low mood was reported by 21% and 36% of psychiatrists respectively (Landers et al., 2010). There are some methodological issues in this study which may bring the validity of the results into question. The questionnaire in this study was based on the personal

experiences and expectations of the authors, which may have led to faulty conceptualisations of the phenomenon being measured. Although the authors collected likert scale data, they failed to report the extent to which participants rated items, reporting only whether they experienced the reactions or not.

These studies suggest that low mood is a likely reaction amongst psychiatrists following patient suicide. However it is difficult to extrapolate the extent of these affects due to the limitations of these studies.

1.4.2.4 Anger

The experience of anger is reported by seven of the studies included in this review. Chemtob and colleagues report a 'moderate' response of anger amongst psychiatrists and psychologists in two separate studies, following patient suicide (Chemtob et al., 1988a, Chemtob et al., 1988b). The term 'moderate' refers to mean responses in the middle third of a 7-point scale. Although the scale is able to measure perceived intensity of reactions, it is limited in that the authors do not offer an explanation to how it was developed.

In a study of social workers' anger towards the 'client' was related to perceptions of being rejected and not trusted, for giving up on life, for being selfish and inconsiderate of how suicide would affect the lives of others (Ting

et. al., 2006). Social workers' in this study also expressed feeling angry at having to deal with those left behind, particularly families. In another study of social workers anger was associated with feeling betrayed by the client and feeling angry towards the 'self' (Sanders et. al., 2005).

Anger at the 'system' for being insufficient, failing to help clients and failing to take responsibility was also reported (Ting et al., 2006, Sanders et al., 2005, Linke et al. 2002), as was anger towards colleagues (Sanders et al., 2005). In one study participants described feeling angry towards supervisors who they felt were more worried about legal issues, than the importance of what had happened (Ting et al., 2006).

In the study of Thai Psychiatrists, anger towards the deceased, family or supervisor was rated as low by the majority of the sample, with only 21.2% reporting a medium to strong response. The authors suggest that the findings may simply reflect Thai cultural norms associated with not expressing anger (Thomyangkoon & Leenaars, 2008). The results of another study suggest that 'irritability at home' was commonly reported by psychiatrists (Alexander et al., 2000). However, this finding is limited by the fact that the authors do not give any further information on this issue, other than it being common.

1.4.2.5 Guilt/ self-blame/ responsibility

Nine of the studies included in this review reported that mental health professionals experienced feelings of either guilt, responsibility and/or engaged in self-blame. Although these concepts could be considered as marginally different, some studies have measured them together, or reported them under the same theme. Chemtob and colleagues (Chemtob et al., 1988a, Chemtob et al., 1988b), reported moderate responses of guilt in psychiatrists and psychologists following patient suicide. They also reported lower levels of guilt in older and more experienced psychiatrists. However, this finding was not replicated in their study of psychologists and should be treated with caution due to the numerous correlations calculated on this data, increasing the chances of a Type 1 error (Curtin & Schulz, 1998).

In a study of psychiatrists and clinical psychologists guilt following patient suicide was reported by 68.3% of the sample, with women experiencing significantly more guilt than men (Grad et al., 1997). This is an important finding with regard to gender differences and may have implications for the support offered to professionals. In response to the open question about initial feelings, guilt was the third most common response for women and the fourth most common for men. As guilt is reflected in answers from both open and closed questions, the validity of this result is strengthened. No differences were found between the professions. The authors suggest this is

because psychologists and psychiatrists have the same level of responsibility for patients in Slovenia where the study was conducted.

Guilt was also ranked as one of the most difficult emotional reactions in response to suicide in the Thai study of psychiatrists (Thomyangkoon & Leenaars., 2008). Fifty-eight percent (of those who responded) rated guilt as having a medium to strong impact. In addition, 14% highlighted guilt and 13% documented self-blame in response to an open question about the impact of suicide. Although it is reported that psychiatrists experienced guilt, it is also reported that 86.9% accepted that their ability to prevent suicide is limited. This brings into question the source of their feelings of guilt and suggests that, although psychiatrists felt guilty, they did not necessarily feel responsible.

Landers et al. (2010) measured feelings of guilt and blame together, and found that 69% of psychiatrists experienced guilt or blame in response to the most recent suicide and 82% to the most distressing suicide. The quantitative data from these studies suggests that guilt following patient suicide is a common reaction amongst psychiatrists and psychologists across cultures, with approximately 60-80% of the samples experiencing this emotion.

Three qualitative studies within this review reported that participants experienced guilt and self-blame. Psychiatrists who judged themselves

harshly reported experiencing an increased struggle with their feelings of grief (Talseth & Gilje, 2007). Social workers questioned whether they could have done something differently, felt that they had not done enough (Ting et al., 2006) and questioned how colleagues and clients now viewed them (Sanders et al., 2005). This latter finding relates to shame, which is only mentioned in two studies in this review. Interestingly, the 17% of participants who reported shame in one study were all female, even though just under half of the sample, were male (Grad et al., 1997). In another study 35% of clinicians described experiencing medium to moderate levels of shame (Thomyangkoon & Leenaars (2008).

Some social workers reported feeling personally responsible (Ting et al., 2006, Sanders et al., 2005) and at the time of the survey some continued to struggle to accept that suicidal behaviour could not be controlled externally by others (Sanders et al., 2005). One participant in another study reported an over-responsible attitude towards patients following patient suicide (Linke et al., 2002). In contrast, Darden and Rutter (2011) found that the clinical psychologists in their study typically did not assume responsibility for their client's death. However, it is suggested by the authors that this may relate to the fact that none of the psychologists were involved in pre-suicide decisions. In addition, the psychologists interviewed thought that ultimately it was the client's choice to take their own life.

1.4.2.6 Trauma

Some of the symptoms most commonly associated with traumatic experiences were found in the clinicians' responses. Social workers in one study described experiencing intrusive memories and visions, disorganisation and emotional numbness following a client suicide, with several experiencing flashbacks at the time of the study (Sanders et al., 2005). Social workers in another study were reported to avoid thoughts and reminders of the suicide (Ting et al., 2006). In addition, moderate levels of emotional numbness and intrusive thoughts about the suicide were also found among psychiatrists and psychologists (Chemtob et al., 1988a & Chemtob et al., 1988b).

Two studies within the review (Chemtob et al., 1988a & Chemtob et al., 1988b) used the Impact of Events Scale (IES) (Horowitz, Wilner & Alvarez, 1979) to assess the impact of patient suicide. This scale measures experiences of intrusion and avoidance related to a specific stressful event. These were the only studies included in the review that have used a data collection tool that is valid and reliable (Sundin & Horowitz, 2002). Using this scale, Chemtob and colleagues (1988a & 1988b) found that both psychiatrists and psychologists had similar mean IES scores following patient suicide to those who had experienced the recent death of a parent (Horowitz et al., 1984, Zilberg, Weiss, & Horowitz, 1982). The studies also found 53% of (122) psychiatrists (Chemtob et al., 1988a) and 49% of (70)

psychologists (Chemtob et al., 1988b) had similar levels of stress to the clinical group. Although the scores on the IES measure generally declined over time, to an 'asymptomatic state' (Horowitz, 1985), the clinical magnitude of the initial reaction cannot be ignored.

Although these findings are of interest and significance they need to be considered in light of the studies' limitations. Firstly, 7% of psychiatrists and 14% of psychologists did not complete this measure. The authors do not report the reason for this, and it is possible that the participants who did not complete the measure may have had a different experience. Secondly, an average score was calculated for one of the items on the avoidance scale which could not be administered due to a transcription error. It is possible that the results would look different if this scale was administered correctly. Thirdly, attempts at contacting non-responders in the psychiatrist study failed. However, similar demographics between psychologists who did and did not take part were verified. Although the study involving psychologists appears to be based on a representative sample, the study is dated and is therefore less likely to reflect the characteristics of psychologists today.

1.4.2.7 Self-doubt

Self -doubt in relation to personal lives was reported by five studies within the review. Chemtob and colleagues (Chemtob et al., 1988a & Chemtob et al., 1988b) found a moderate loss of self-esteem in their studies.

Furthermore, they found that the more years a psychiatrist had in practice, the smaller this effect was. However, this finding should be treated with caution due to the chances of a Type 1 error. Self-doubt (Linke et al., 2002, Kelleher & Campbell, 2011, Talseth & Gilje, 2007) and decreased self-confidence (Alexander et al., 2000) were also reported in other studies. However, due to a lack of information reported in these studies, it is difficult to know the impact of this.

1.4.2.8 Disturbed sleep

Disruption to sleep was reported in half of the studies included within this review. Poor sleep (Alexander et al., 2000), disturbed sleep (Linke et al., 2002), no sleep (Ting et al., 2006) and mild to moderate levels of intense dreaming and dreams about the suicide (Chemtob et al., 1988a & Chemtob et al., 1988b) were reported. Landers et al. (2010) found more disrupted sleep in relation to the most distressing suicide (42%) than the most recent suicide (27%). From these studies it can be seen that there is some evidence that sleep disturbance is a feature for clinicians following patient suicide.

1.4.2.9 Impact on personal relationships

Four studies have reported evidence to suggest that experiencing patient suicide can have an impact on the professional's personal relationships. Following patient suicide, Alexander et al. (2000) reported that psychiatrists

in their study were less able to deal with routine family problems following patient suicide. Another study reported that the family (30%) and friends (17.5%) of psychologists and psychiatrists noticed an emotional change in them (Grad et al., 1997). Levels of social withdrawal and disruptions in relationships with family, friends and colleagues were reported to be low in studies of psychiatrists and psychologists (Chemtob et al., 1988a & Chemtob et al., 1988b).

1.4.2.10 No Impact

Small numbers of participants within six of the studies included within this review reported that patient suicide had no impact on their personal lives (Linke et. al., 2002, Thomyangkoon & Leenars, 2008, Landers et. al., 2010, Sanders et. al., 2005, Ting et.al., 2006, Darden & Rutter, 2011). Some of the clinical psychologists in one study were reported to be ambivalent when asked to acknowledge any personal impact and half the sample deflected from questions about personal impact by talking about the impact on others (Darden and Rutter, 2011).

1.4.2.11 Positive – personal growth

Despite the majority of reported reactions to patient suicide being of an adverse nature, feelings of personal and professional growth as a result of the suicide were reported in a group of social workers (Sanders et. al., 2005) and in 91% of psychiatrists (Thomyangkoon & Leenaars, 2008). Fifteen

psychiatrists reportedly used the experience to help other clinical cases (Thomyangkoon & Leenaars, 2008).

1.4.2.12 Summary of Personal Impact

The studies in this review provide evidence to show that personal responses to patient suicide include a range of emotional reactions such as shock, denial, sadness, grief, low mood, anger, guilt, self-blame and feelings of responsibility. Guilt appears to be the most frequently reported reaction, with 60-80% of psychiatrists and psychologists experiencing guilty feelings across cultures, with some evidence showing females experience more guilt than their male counterparts. Sadness was also prevalent across studies and was reported to have had an impact on the clinician in a personal way. Anger was reported to be directed towards a range of sources, with shock and denial appearing to have a lesser impact on the clinicians. Responses that could be associated with trauma were also found, which gives some indication of the intensity of the impact of patient suicide for clinicians.

1.4.3 Professional Impact

Most of the studies within this review report findings on the professional impact of patient suicide.

1.4.3.1 Self doubt at work.

Six studies report self doubt at work following patient suicide. Self doubt at work manifested itself amongst social workers as doubting one's own abilities, feeling incompetent and the fear of being judged by colleagues and patients' families (Sanders et. al., 2005, Ting et al., 2006). Members of multi-disciplinary teams were also reported to experience feelings of self-doubt and anxiety at work following patient suicide (Linke et. al., 2002). However, due to the small unrepresentative sample the results should be viewed with caution.

A decreased sense of confidence at work was reported by psychiatrists in relation to both the most distressing (68%) and the most recent (52%) suicide (Landers et al., 2010). A sense of helplessness in making decisions and increased anxiety in relation to working with patients' families, admitting patients to wards and prescribing antidepressants was also reported by psychiatrists in another study (Kelleher & Campbell, 2011). In contrast, Thomyangkoon and Leenars (2008) found low levels of self doubt among psychiatrists, with only 2.6% experiencing self doubt at strong levels. Although important, self-doubt does not appear to be experienced by all professionals or reported by all studies.

1.4.3.2 Review of actions

Two thirds of the psychologists in a qualitative study questioned whether they could have done something differently following a patient suicide (Darden and Rutter, 2011), as did social workers (Ting et al., 2006). Ninety-five percent of psychiatrists in another study persistently reviewed their actions to see if there was something they may have missed (Thomyangkoon and Leenars, 2008). The findings of this last study are limited by the use of a questionnaire selected due to availability. Although translated into Thai, it was not subject to normative analysis with a Thai population.

1.4.3.3 Heightened awareness of risk

Increased focus on suicide cues following patient suicide was reported in six studies. Increased awareness of suicidal ideation (Ting et al., 2006) and suicide issues (Sanders et al., 2005) were reported by social workers. Moderate levels of increased focus on suicide cues were also reported by psychiatrists and psychologists (Chemtob et al., 1988a & Chemtob et al., 1988b). In one study of psychologists, over half of the participants reported becoming hyper-vigilant and seeking out risk factors. High levels (87-88%) of increased awareness were found in other studies of psychiatrists (Landers et al., 2010). Increased risk awareness was a commonly reported change to practice (Alexander et al., 2000).

1.4.3.4 Caution in treatment and increased assessment of risk

Increased caution in the treatment of suicidal clients was identified as a reaction to patient suicide in a number of studies. This took the form of being more cautious (93.6% in Grad et al., 1997) and defensive (Alexander et al. 2000) with risk, making fewer assumptions about suicidal people (Ting et al., 2006) and being increasingly reluctant to discharge patients (Kelleher & Campbell, 2011). An increase in the number of risk assessments conducted was also reported amongst social workers (Ting et. al., 2006), with psychologists increasing their inquiry about clients' commitment to life (Darden & Rutter, 2011). Furthermore, 93.4% of psychiatrists reported conducting a more aggressive search for suicidality (Thomyangkoon & Leenaars, 2008).

1.4.3.5 Selection and Avoidance of patients

Most clinicians within the studies appeared to continue working with high risk clients following a patient suicide (Thomyangkoon & Leenars, 2008, Alexander et. al., 2000). Grad et al. (1997) reported 60.3% of their sample of psychiatrists and psychologists continued working as usual. However, some studies, found that, following patient suicide, small number of participants either avoided or were more selective of the patients that they worked with. Mild changes in patient selection were reported in psychiatrists and psychologists in another set of studies, with younger psychologists being found to be more likely to alter their selection of patients than older

psychologists (Chemtob et. al., 1988a & Chemtob et al., 1988b). This latter finding may be due to chance and therefore should be considered with caution.

A study of multidisciplinary teams (Linke et al., 2002) reported small numbers of participants avoiding clients perceived to be at risk. Some social workers in another study preferred not to see clients if they were suicidal and transferred them on to other colleagues (Ting et al., 2006).

Small numbers of professionals considered changing their job following patient suicide (Linke et al., 2002, Landers et al., 2010, Thomyangkoon & Leenars, 2008), with some clinicians actually leaving their job in one study of social workers (Ting et al., 2006). Similarly, low numbers of psychiatrists were found to consider taking early retirement in other studies (Alexander et al, 2000, Kelleher & Campbell, 2011).

1.4.3.6 Summary of Professional Impact

The studies within this review provide evidence to show that patient suicide has various effects on the clinician in their role as a professional. Three studies reported that professionals reviewed their actions in relation to the patient suicide and six studies reported that professionals doubted their own abilities at work. Although the evidence for self-doubt is based on only half the studies within this review, it brings into question how these feelings impact on future practice.

The majority of studies reported increases in awareness and assessment of risk, and caution in treatment of patients following a patient suicide. The quantitative research within this review suggests that this type of reaction is common, with between 87-93.6% of the samples reporting it as a change to practice.

Fortunately the literature suggests that only a small amount of clinicians avoided clients following a patient suicide, with the majority reported as continuing to work with high risk patients. This could be considered as a positive for ongoing patient care. It does, however, raise the question whether clinicians can continue working as usual whilst experiencing strong emotions such as guilt, sadness and, in some cases, traumatic responses.

1.4.4 Coping and recovery following patient suicide

Utilising sources of support and finding other ways of coping with the impact of patient suicide may serve to promote the health and well-being and possibly, the resilience of professionals. Such support and coping may facilitate ongoing effective work with clients.

Talking with others and self-reflection were reported to be helpful in a qualitative study of psychiatrists (Talseth & Gilje, 2007). The authors report that these strategies shifted psychiatrists' perspectives, moving them from a

place of grief to consolation. Shifts from self-doubt to self confidence as their self-blame turned to courage and from voicelessness to restored voice as psychiatrists retold their story to others were reported to be helpful.

Although this study is useful, in that it sheds some light on possible internal processes that may help psychiatrist's to become consoled, it has many limitations. Firstly, the data for this study is extracted from a larger study based on the experiences of working with suicidal clients. Although the psychiatrist's interviews were based on their experience of a patient's suicide, the results are presented in a confusing way and incorporate reflections about the patient before they died. Secondly, the interpretation of the data may have been influenced by a model of consolation (Norberg, Bergsten, & Lundman, 2001) which was under investigation, leaving no room for alternative interpretations. Thirdly, the interviews were conducted in Norwegian and translated into English before being analysed, which may have led to the semantic nature of the interviews being subject to change.

Talking with others was the most commonly sought and most helpful source of support reported by the participants across the studies and is consistent with the findings of Talseth and Gilje (2007).

1.4.4.1 Support from colleagues

Many of the studies in this review report that, following a patient suicide, clinicians commonly sought out informal support from their colleagues

(Chemtob et al, 1988a & Chemtob et al, 1988b, Landers et al, 2010, Grad et al, 1997). Across the studies the majority (60-93%) of clinicians rated the support they received from colleagues, team members and other mental health professionals as helpful (Alexander et al., 2000, Linke et al, 2002, Kelleher & Campbell, 2011, Landers et al., 2010, Thomyangkoon & Leenaars 2008). Accessing such support appears to be the most common and most helpful way of coping for clinicians following patient suicide. Colleague support was reported to facilitate recovery (Darden & Rutter, 2011) and to help clinician's to continue to work effectively (Ting et al., 2006). Some studies also identified an appreciation for skilled supervision (Linke et al., 2002) and talking with their supervisor as being helpful (Darden & Rutter, 2010). In one study of psychiatrists, more than 90% of the sample rated supervision as helpful (Thomyangkoon and Leenars (2008). This finding contrasts to being angry with supervisors as discussed earlier (Ting et al, 2006).

1.4.4.2 Support from own family and friends

Five of the studies also report that professionals sought support from their own family and friends following patient suicide. High proportions of the samples (81-93%) reported support from these sources as either helpful or very helpful (Linke et al., 2002, Alexander et al., 2000, Kelleher & Campbell, 2011, Thomyangkoon & Leenaars, 2008). Twenty percent of psychiatrists in

one study reported that family support was the greatest benefit to them, above support from colleagues (Landers et al., 2010).

1.4.4.3 Gender differences in coping

Marked gender differences in coping were found in a study of psychiatrists and psychologists (Grad et al., 1997). Men seemed to find working (30%) and talking (30%) most helpful, whereas 75% of women found talking most helpful, with a few identifying working as helpful.

1.4.4.4 Staff meetings

There was a mixed response to how helpful staff meetings were for professionals. In two studies of psychiatrists professional meetings were considered as helpful by 87.5% (Thomyangkoon & Leenaars, 2008) and 86% (Alexander et al, 2000) of the samples. In another study team meetings were considered helpful by 65% of the sample but unhelpful by 25% (Kelleher & Campbell, 2011), with some psychiatrists reporting they felt blamed in these arenas. In another study, members of a multi-disciplinary team found receiving acknowledgement of the impact of the event, whilst not being blamed was important, with staff meetings being helpful if handled carefully (Linke et al, 2002).

1.4.4.5 Formal meetings/reviews

One study reported that reviewing the patient's case, conducting psychological autopsies and group debriefings helped social workers to reach a resolution and reduce feelings of personal responsibility, guilt and self-blame (Ting et al., 2006). Alexander et al. (2000) found that critical incident reviews only took place in 50% of cases. However, they were considered helpful by 68% of those who attended, and were thought to lead to the improved management of suicide and its aftermath. Formal case reviews were provided in 61-66% of cases in another study (Landers et al, 2010). However, the paper does not specify how helpful participants found them.

1.4.4.6 Official enquiries

There was some unease reported about the manner in which official inquiries were conducted (Linke et al., 2002). Legal and disciplinary proceedings and fatal accident enquiries were viewed unfavourably (Alexander et al., 2000). Free text comments relating to such proceedings included terms such as 'scape-goating', 'blame culture' and even 'witch hunting' (Alexander et al, 2000).

1.4.4.7 Justification and Acceptance

Two studies reported that social workers attempted to justify their actions to facilitate coping. In one study the theme of 'justification' related to narratives

about the client's self determination and choice in the suicide. This linked to absolving oneself of blame as did the theme of 'acceptance' which reflected feelings of forgiveness (Ting et al., 2006). Acceptance was especially evidenced when there was support from others regarding responsibility. Similarly, Sanders et al. (2005) reported that to reduce feelings of trauma the social workers in their study re-examined their relationship with the client to determine their level of responsibility, and justify the client suicide.

1.4.4.8 Helpfulness of support and participants suggestions for support

Overall, support from colleagues was reported to be the most beneficial source of support across studies. Team meetings and reviews were considered helpful by most, with the caveat that issues of blame and responsibility are carefully managed. Feeling blamed in relation to official enquiries was reported, with support from others regarding responsibility facilitating acceptance of what had happened.

Participant's suggestions for post-intervention following patient suicide included allocating a chairperson at team meetings to ensure there is no blame (Kelleher & Campbell, 2011), having clinically led reviews that separate the legal consequences from the incident (Alexander et al, 2000) and the provision of medico-legal assistance in the event of litigation (Landers et al, 2010). Increased availability of formal, though optional, methods of support for clinician's e.g. grief counseling (Alexander et al,

2000, Landers et al, 2010, Darden & Rutter, 2011) were also suggested.

Public acknowledgement of the impact of patient suicide on team members by senior staff (Linke et al, 2002) and group supervision for staff (Darden & Rutter, 2011) have also been suggested.

1.5 Discussion

1.5.1 Methodological Critique

The limitations of specific studies have been discussed in the main body of the review. Some of the more fundamental limitations that apply across the majority of studies will be discussed here, before the quality of the studies can be properly assessed.

A cross-sectional study design was used by the majority of studies within the review. Cross-sectional designs are limited by their inability to control for confounding variables or to ascertain information about the relationships between variables. The majority of studies within this review used postal surveys to collect their data. Although postal surveys are geographically flexible, they are often subject to low response rates, as with some of the studies reviewed here. Anonymity within surveys protects participants' identities; however, this means that it is impossible to clarify answers, which can result in receiving incomplete or illegible data. It is for this reason that participants in four of the studies were removed from the analysis (Chemtob et al., 1988a & Chemtob et al, 1988b, Sanders et al., 2005 & Landers et al.,

2010). Other studies were also limited by missing data (Grad et al., 1997, Alexander et al., 2002, Thomyangkoon & Leenars, 2008). Overall, the sample sizes in these studies are small and are reduced further by these methodological limitations. Darden & Rutter (2011) question whether their recruitment difficulties reflect the potential embarrassment and re-living of feelings, participation in suicide research may elicit.

A number of differences across the studies make it difficult for the results of this review to be generalised. Participants comment on a range of suicides across studies including the most recent, most distressing, those who were actively in treatment and others do not specify. There are also differences in the data collection tools used across studies, with most using non-validated tools and providing little information about their development. Differences with regard to culture and the settings where the clinicians work also exist. This makes comparisons between studies difficult and to some degree limits the applicability of the results of this review.

The qualitative studies within the review demonstrated their trust worthiness by providing clear descriptions of the methodology and analysis process used. They also minimised threats to credibility by employing observer triangulation, with two of the studies using member checking to clarify answers of participants (Darden & Rutter, 2011, Ting et al., 2006). All qualitative studies provide evidence to support their themes, with Sanders et

al. (2005) demonstrating that they were open to alternative explanations. In the qualitative studies, examples of research questions were provided by the authors. However, only one study specified how the questions were developed (Darden & Rutter, 2011).

Finally, the retrospective nature of these studies lend themselves to inaccuracies, as responses are based on participants' memories of events. In one study participants reported their reactions to suicide that occurred up to 40 years ago (Landers et al., 2010).

1.5.2 Limitations of review

This review is limited by the fundamental methodological flaws across all of the studies, as discussed above. It can be argued that the overall quality of evidence for the reactions and coping processes of professionals following a patient suicide is low and thus, the conclusions that can be drawn from it are tentative.

The use of a quality assessment tool was considered to assess the quality of the studies included within this review, as it has been suggested that this ensures a reliable and standardised way of critically appraising studies (Centre for Reviews and Dissemination, 2009). However, it was deemed appropriate not to use one here. The main reason for this was that assessment checklists are often specific to study design and it was difficult

to find a set of criteria to fit the research designs used in these studies. This is due to the range of research designs of the studies: they included quantitative surveys, surveys using mixed methods and more traditional qualitative studies. None of the studies meet the criteria for experimental or quasi-experimental research which most of the assessment checklists are geared towards. Secondly, methodological issues pertaining to the studies have been discussed throughout the review and in the section on methodological critique. This was deemed an appropriate way of considering study quality.

The review attempted to synthesise the reported experiences of qualified mental health professionals who are likely to work in public services. This meant that articles pertaining to psychotherapists who are more likely to work in the private sector were excluded from the review. In addition, articles including unqualified professionals were excluded from this review. These decisions were made to make the review as focused as possible. Despite this the review did include mental health professionals working across a range of disciplines. Literature searches revealed no articles pertaining to occupational therapist's reactions to patient suicide. This would suggest a lack of research in this area. Therefore the results of this review cannot be generalised to all workers in the field of mental health.

1.5.3 Areas for future research

Suggestions for future research relate to improving the quality of the research by addressing existing methodological issues. To improve the external validity of findings, future research may benefit from finding ways to increase the participation rates in studies on mental health professionals' reactions to patient suicide. If, as some authors suggest (Darden & Rutter, 2011), low response rates in this area are due to embarrassment or feared emotional distress, this task will be no easy feat. It may be that a culture change amongst professionals from feelings of being blamed to being supported may improve participation rates.

The representative nature of the studies could be improved by using sampling strategies that allow comparison between participants and non-responders to be made. The development of reliable and valid data collection tools would also allow comparisons across studies. Research with a specific focus on coping with patient suicide may be clinically useful.

1.5.4 Clinical Implications

Seeking informal support from colleagues following patient suicide should be encouraged and supported by the institutions in which professionals work. This type of support was reported to be the most common source of support utilised by participants, the majority of whom rated it as helpful. It may also be useful to bear in mind gender differences in coping when attempting to

support professionals. Although gender differences may be important, the individual needs of the practitioner are likely to override this.

The somewhat mixed response to formal support, formal proceedings and official inquiries engaged with by the participants, appears to be linked to how they are managed with regards to blame and implied responsibility for the patient suicide. Participants across some of the studies have identified different types of formal support that they believe would be helpful including group supervision and acknowledgement of the impact of patient suicide by senior members of staff.

Raising mental health care providers' awareness of the personal and professional reactions to patient suicide and the detrimental impact of blame on the coping process, would be beneficial in dealing with the aftermath and implementing support systems to meet professional's needs. Meeting the needs of clinicians may reduce the adverse impact on them, both personally and professionally and this is likely to have a positive impact on patient care in turn.

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Chapter 2: Empirical Paper

Experiences of working in a crisis team: An exploration of emotional coping.

2.1 Abstract

The phenomenon of stress and burnout in mental health professionals has been well documented in the literature. Crisis Resolution Home Treatment (CRHT) teams work with people in acute psychiatric crisis. This is the first known study to explore the emotional experiences and associated coping responses of mental health professionals working in a CRHT team. Seven clinicians participated in semi-structured interviews and the data were analysed using interpretative phenomenological analysis (IPA). Three superordinate themes emerged from the analysis of the interview data: 'Response to difficult emotion', 'Impact on self' and 'Intergroup processes'. The findings bring to light the clinician's fear of client suicide and the impact it has on their sense of competence in making decisions about risk. The findings also highlight the role of avoidant coping in managing emotions associated with crisis work. Relationships with colleagues and their influence to both facilitate and impede emotional well-being at work were also emphasised.

Keywords: emotions, coping, crisis intervention services, mental health personnel, phenomenological

2.2 Introduction

The expansion of Crisis Resolution Home Treatment (CRHT) teams was prescribed as part of the National Health Service (NHS) plan (Department of Health, 2000). CRHT teams are set up for people experiencing acute mental health crises and aim to provide rapid assessment and short term treatment in the least restrictive environment, offering an alternative to hospital admission where appropriate. There has been some research conducted to assess their effectiveness (Irving, Adams & Rice, 2006), however little is known about how the nature of these teams impact on the clinicians who work in them (Nelson, Johnson & Bebbington, 2009). Professionals who typically work in CRHT teams include community psychiatric nurses, approved mental health practitioners, occupational therapists, psychologists, and support workers, with some involvement from psychiatrists (DOH, 2001).

2.2.1 Stress and Coping in Mental Health Clinicians

Occupational stress and burnout in mental health workers is well documented in the literature. There is now substantial evidence to demonstrate high levels of stress and burnout in mental health nurses (Edward & Burnard, 2003), occupational therapists and social workers (Lloyd, McKenna & King, 2005), psychiatrists (Fothergill, Edwards & Burnard, 2004) and psychologists (Cushway & Tyler, 1996). Evidence also

demonstrates lower levels of well being and higher levels of burnout in mental health professionals than in other healthcare occupations (Reid et al. 1999, Walsh & Walsh 2001, Lin, Probst & Hsu, 2010). Being in a state of stress or burnout is likely to have an effect on the patients being cared for within services. Coffey (1999) suggests that mental health workers experiencing high levels of emotional exhaustion may experience difficulty in developing strong and trusting relationships with clients. Therefore, the management of stress at work is important for both staff and patients.

The research base identifies a range of coping strategies used by mental health workers to cope with the stress they experience at work. These include social support, recognising limitations, supervision and establishing an effective work-life balance (Edwards and Burnard, 2003), to name but a few. Protective factors identified to reduce the impact of stress include high levels of self esteem, personal control and good physiological release mechanisms (Edwards, Hannigan, Fothergill & Burnard, 2002).

According to Trenberth and Dewe (2004), 'stress' and 'coping' are often researched with rigid quantitative methods as if they were two separate concepts, resulting in findings that lack clinical relevance. They suggest the use of alternative methodologies such as qualitative, interpretative and meaning-centered methods, in order to capture the complexity of emotional coping processes.

Stress is a complex process and there has been much debate in the literature over its precise definition. Baum (1990) suggests stress is a 'negative emotional experience accompanied by predictable biochemical, physiological and behavioural changes' (p. 653). Lazarus and Cohen-Charash (2001) point out that in the past the literature on stress and the literature on emotions have been established separately. They argue that because stress produces emotional consequences the two should be studied as one topic. Lazarus and Cohen-Charash (2001) also argue that more can be learned about the appraisal and coping process in relation to stress, from drawing on information about individual emotions experienced rather than measuring the extent of the stress response.

2.2.2 Emotional Management

It has been argued that 'work-stress and coping cannot be determined without first considering the role of emotions' (Trenberth & Dewe, 2004, p.150). Considering the emotional demands of working in mental health settings is important when looking at ways to manage clinicians' stress (Mann & Cowburn, 2005). More recently the importance of the emotional demands of working within mental health settings has been acknowledged and become the focus of research. In order to provide effective care, clinicians will need to find ways to manage their own emotional responses to

clients suffering that are likely to arise by connecting with a client on an emotional level (McQueen, 2004).

Work with an emotional demand such as caring is referred to in the literature as 'emotional labour'. This term describes the effort made by individuals to 'regulate emotional display to sustain an outer appearance that results in others feeling cared for and in a safe place' (Hochschild, 1983 as cited in McQueen, 2004, p. 103). Emotional labour has been found to benefit patients and clinicians. For patients, it helps them feel cared for and is important for building a therapeutic relationship (Mann, 2004). For clinicians, it allows them to engage with clients on a personal level (Huynh, Alderson & Thompson, 2008), offering a sense of professional accomplishment and job satisfaction (McQueen, 2004). Emotional labour has however, been found to have a relationship with stress in clinicians (Mann, 2004). Mann & Cowburn (2005) investigated the link between emotional labour and stress in mental health nursing. Positive correlations suggested that the more emotional labour was invested, within an interaction, the more stressful the interaction was for the mental health nurses. Furthermore, daily stress was reported to be higher in nurses who made more of an effort to regulate their emotions in this way.

The literature suggests that the consideration of emotions and their management are important in understanding the needs of clinicians in terms

of occupational stress. As with the stress and coping literature the use of quantitative methodology in the research of emotions has been questioned. Bulmer-Smith, Profetto-McGrath and Cummings (2009) argue that research investigating the meaning and nature of emotion in nursing practice and the caring environment is warranted. Fineman (2004) suggests that it may be more ethically appropriate to research emotions without measuring them. Overall the literature points to the use of alternative approaches such as qualitative methodology to explore the role of emotion in both the stress elicited and coping needed to manage the demands of working in mental health settings.

2.2.3 Research on Clinician's experiences of working in CRHT teams

Nelson et al. (2009) aimed to assess levels of burnout, sources of stress and sources of job satisfaction within United Kingdom (UK) Crisis Resolution teams (CRHT) and compare the results to previous studies of Assertive Outreach (AO) and Community Mental Health teams (CMHT). The study of CRHT staff included data from 132 clinicians from 11 CRHT teams across London. The findings showed that clinicians were moderately satisfied with working in a CRHT team and on the whole reported average levels of emotional exhaustion and low levels of depersonalisation with regards to burnout.

Sources of stress specific to CRHT's included working with suicidal and/or violent people in their home and being called out at night. Clinicians' in CRHT's rated lack of support from senior staff and poor communication within the team, as more important sources of stress than the staff in the other types of team. The authors suggest that although the demands of working in a CRHT are high, the potential effects of burnout may be moderated by factors specific to CRHT's. Sources of job satisfaction identified by participants such as keeping clients out of hospital, the teamwork approach, observing rapid changes in clients and having a sense of autonomy, were suggested as moderating factors.

Although this study offers some suggestion to account for low levels of burnout it does not offer any information on the clinician's individual experience or how they cope emotionally. Such information may provide further understanding of the experience of crisis team clinicians and shed light on the information gained from Nelson et al. (2009) regarding satisfaction and burnout.

A recent study by Freeman, Vidgen and Davis-Edwards (2011) aimed to explore clinicians' experiences of working in a UK CRHT team with a particular focus on enjoyable aspects of the job, stressful aspects of the job and how clinicians cope with these stressors. Qualitative analysis revealed three main themes, which were: motivating factors, stressors and coping.

Motivating factors included helping clients to feel empowered and experiencing a sense of achievement when clients began to recover from crisis. Stressors included factors such as; a misunderstanding from outside professionals about the role of the crisis team and a lack of resources. In terms of coping, Freeman et al (2011) found that clinicians used individual strategies of emotional regulation and also drew on the resources in the team for emotional support, informational support and support from managers.

Edward (2005) aimed to explore the phenomenon of 'resilience' as experienced by mental health clinicians involved in crisis care in Australia. In this study the authors defined resilience as 'the ability of an individual to bounce back from adversity, persevere through difficult times, and return to a state of internal equilibrium or a state of healthy being' (Edward, 2005, p.142). Five themes relating to resilience were found; the team as a protective factor to stress, sense of self, faith and hope, having insight, and looking after oneself. The study is limited in that the author provides an inadequate amount of data to support the findings.

2.2.4 Rationale

The research reported here is useful as it offers information about the sources of stress, levels of burnout and the mechanism of resilience in mental health clinicians working in crisis care and how clinician's cope with stressors. The importance of considering the role of emotions in the stress response was discussed earlier, however to date there is no research into the individual emotional experiences and associated coping processes of CRHT clinicians. As such it seems important to explore their emotional experiences as they may be qualitatively different from professionals in other mental health settings. Furthermore, it is hoped that the findings will be valuable in developing a more detailed understanding of the emotional needs of crisis team clinicians, which in turn will have an implication for improving their wellbeing and the quality of care they deliver.

For the remainder of this paper the CRHT team will be referred to as the Crisis Team.

2.2.5 Aim and Research Questions

The main aim of this study is to explore the emotional experiences of clinicians working in a Crisis Team. The following research questions have been developed to aid this principal aim:

- What are the clinician's emotional experiences of working in a crisis team?
- How do crisis team clinicians cope with the emotions they experience?
- How do work related emotions impact clinician's personally and professionally?

2.3 Method

2.3.1 Ethical Approval

Ethical approval was granted from Coventry University (Appendix C), the National Research Ethics Committee West Midlands – Solihull (Appendix D) and the West Midlands (South) Comprehensive Local Research Network (Appendix E).

2.3.2 Design

A qualitative design has been chosen for the present study for a variety of reasons. Firstly, a qualitative method has the ability to meet the aims of this study, which is to capture experientially orientated data. Secondly, a qualitative approach is useful when little is known about a topic as it provides the opportunity to gain an in-depth understanding of a phenomenon, before hypotheses can be generated and tested. Thirdly, using a qualitative approach, overcomes a number of the criticisms of previous quantitative methods that dominate the stress and coping literature.

Data was collected using semi-structured interviews to encompass the aims of the phenomenological inquiry. Semi-structured interviews allow flexibility to modify questions and probe for more information in light of participant's responses. They also allow the participant to have a share in the direction of the interview with the possibility of uncovering novel areas and producing richer data (Smith & Osborn, 2008).

2.3.3 Participants and Recruitment

Seven participants were recruited from a single Crisis team in the West Midlands region of the UK. The initial stage of recruitment involved presenting information about the project to potential participants at a team meeting. As part of the presentation, information sheets (Appendix F) were distributed to the staff group summarising the study. Twelve team members were then invited by email (Appendix G) to take part in the study and were asked to respond if they were interested. Participants met the inclusion criteria if they were currently working clinically for the team. Five team members registered their interest following the first email however two of these were excluded due to their managerial and administrative roles. An additional two participants identified their interest by responding to a follow up email sent two months later. The final two participants indicated their interest to the team psychologist who was also the author's Clinical Supervisor. Of the remaining three team members one was on leave at the

time which may explain why they did not respond and no response was received from the other two.

As Interpretative Phenomenological Analysis (IPA) is concerned with the interpretation of data rather than the quantity, seven participants was considered to be sufficient to meet methodological commitments. The number of participants within this study is supported by the recommendations made by Morse (1994 as cited in Sandelowksi,1995) and Smith, Flowers and Larkin (2009).Table 2 summarises participant information.

Table 2: Participant Information

Gender	Male	1
	Female	6
Age	Mean	44
	Range	31-57
Profession	Psychiatric Nurse	6
	Occupational Therapist	1
Time Qualified (years)	Mean	18
	Range	4-31
Time in Crisis Team (years)	Mean	4.88
	Range	0.16 -9

2.3.4 Materials

A semi-structured interview schedule (Appendix H) was developed by the research team, using the principles outlined by Smith, Flowers & Larkin (2009) for guidance. Questions were developed to reflect the aims of the study and the existing stress and coping literature was considered to highlight potentially important topics. The interview schedule was reviewed following the first interview and changes were made to the opening question to promote the initial rapport between the interviewer and participant.

2.3.5 Interview Procedure

All seven of the interested participants gave their consent (see appendix I for consent form) to be interviewed by the lead researcher for the purposes of the study. The interviews were conducted between July and November 2011 at the participant's place of work. The interviews were recorded using audio equipment and lasted between 45 and 80 minutes. Following the interviews participants were given a debriefing sheet (Appendix J), which provided contact details of support they could draw upon if they felt distressed as a result of taking part in the study.

2.3.6 Analysis

Each interview was transcribed verbatim and analysed using Interpretative Phenomenological Analysis (IPA) as outlined by Smith et al. (2009). IPA adopts a phenomenological position, therefore examines how people make

sense of their experience. IPA was deemed to be the most appropriate method to meet the experiential aim of this study. Further details on the analytic process can be found in appendix K and an extract from an analysed transcript in appendix L.

2.3.7 Position of the Researcher

During the research process the lead researcher was employed as a Trainee Clinical Psychologist working independently from the team. The lead researcher worked clinically from a psychodynamic perspective in the months preceding the data analysis stage, thus it is likely that models such as Luborsky (1984) and Malan (1995) may have influenced this process. As a result the researcher may have been more likely to consider relational and unconscious processes when exploring the data.

2.3.8 Validity

Guidelines produced by Yardley (2000) suggest that sensitivity to context, commitment, rigour, transparency, coherence; and the impact and importance of research should all be considered to improve the quality in qualitative research. These issues were considered throughout the research process and used as a guide to enhance the quality of the study.

Input and supervision was received from two clinical psychologists both with experience of working with crisis team clinicians and one with experience of

supervising IPA research. Themes emerging from the data were discussed in supervision and related back to the participant's accounts. In addition, a fellow researcher, also conducting IPA research, reviewed the emergent themes for one whole transcript to clarify that they were grounded in the data.

2.4 Results

IPA analysis revealed three superordinate themes with 10 accompanying subthemes within the data.

The first superordinate theme, 'Response to difficult emotion' encapsulates the ways in which participants coped with their emotions. It includes four subthemes: 'transformation of emotions to self-soothe', 'self-protection' 'prevention of emotional expression' and 'social coping through colleagues'. The subthemes reflect both intrapersonal and interpersonal ways of coping as described by the participants.

The second superordinate theme 'Impact on self' is more interpretative in nature and includes three subthemes: 'self in relation to clients', 'self at work', and 'self at home'. This theme emerged from participants' descriptions about how the nature of the work impacts on feelings about the 'self'.

The third superordinate theme 'Intergroup processes' is concerned with the experience participants have in relation to their colleagues and includes three subthemes: 'shared experience', 'interpersonal difficulties' and 'emotional contagion'. A summary of the themes and their associated subthemes can be found in table 3.

Table 3: Superordinate themes and subthemes

Superordinate Themes	Subthemes
Theme 1: Response to difficult emotion	Transformation of emotions to self-soothe Self-protection Prevention of emotional expression Social coping through colleagues
Theme 2: Impact on self	Self at work Self in relation to clients Self at home
Theme 3: Intergroup processes	Shared experiences Interpersonal difficulties Emotional contagion

The superordinate themes and subthemes will be presented below, using extracts from participant's transcripts for illustration and exploration.

Participants have been assigned pseudonyms to protect their identity. All

pseudonyms chosen are female to ensure that the only male in the sample remains anonymous.

2.4.1 Superordinate Theme 1: Response to difficult emotion

All seven participants talked about how they attempted to cope with their difficult emotions in relation to work. The subthemes reflect how the participants make sense of different ways of coping.

2.4.1.1 Subtheme: Transformation of emotions to self-soothe

All participants reported to engage in emotion-focused coping. This subtheme encapsulates the potential meaning for participants in employing emotion-focused strategies. It is interpreted that the participants employed strategies in an attempt to soothe themselves through changing their emotional state. For example the language Claire uses to describe her experience of coping implies it has remedial properties:

Claire: Spend time with my family and the (children) and that there acts as a panacea, sometimes for this place (Lines 269-271).

A 'panacea' or remedy implies the strategy has a curative function, therefore it is interpreted that Claire experiences the crisis team as being diseased in some way and in need of an antidote. Claire later goes on to describe how spending time with the children brings her 'a great deal of pleasure' (Line

302), thus changing the ways she feels. Kate spoke about going into 'pampering me mode' (Line 775) as a way of coping, then went on to identify ways in which that was helpful:

Kate:...it just kind of washes it really and cleans it I suppose (Lines 791-792).

It is interpreted that the cleansing nature of Kate's coping strategy may imply that difficult emotions are experienced as contaminating. Ruth talked about the releasing effect of watching 'soppy movies' (Line 672) in response to difficult emotions:

Interviewer: And sometimes watching soppy movies might be ...?

Ruth: terrible and it makes you cry (laughs) it really lets out some emotions. Oh isn't that sad and you start bursting into tears and crying (Lines 680-684).

This subtheme suggests that the participants respond to their difficult emotions in an attempt to restore a sense of internal equilibrium.

2.4.1.2 Subtheme: Self-protection

All participants described ways of coping that could be interpreted as a way of protecting themselves from difficult thoughts or emotional experiences. For example Ann 'used alcohol...so I don't think about...you know things (Lines 271-272) and Rose spoke about 'distractions and diversions to make it a bit more tolerable' (Line 492). It is interpreted that at some level these types of strategies serve as a defence mechanism to protect the self from the experience.

Ruth describes responding to her emotional experiences by going into 'me mode' where she thinks 'forget everybody else, just me' (Lines 436-438). She also describes making a conscious effort to protect herself by using an imaginary bubble:

Ruth: I have decided now that I am going into a bubble. I have said to people that I am in a bubble. Nobody is going to pop it (laughs). So try to let things bounce off you and try not to take anything personal, whether it is personal or not, that's their problem not mine. And it has been working for the past two weeks (Lines 700-704).

This imaginary bubble seems to provide Ruth with a safe space which cannot be penetrated by other people. Thus, it protects her from getting 'depressed or down or sad' (Line 697). Throughout the interview with Rose it became clear that she struggled with periods of inactivity within the team,

describing them as 'excruciatingly painful' (Lines 426 & 465). As a way of blocking the thoughts that accompany this feeling, Rose describes how she devised a protective strategy:

Rose: I try and consciously try and not look at the board and see what the work is there. I try and come in and put my bag down and say hello to everybody and then go and make a drink and go and just wait for handover and find out then, rather than getting caught up in all those thoughts of 'it doesn't look like there is much' and all that sort of stuff so (Lines 596-601).

For Rose, avoiding looking at the board prevents her from engaging in difficult thoughts. The next quote illustrates how Claire engages in self-protection:

Claire: I try and actively avoid talking about my emotions. Not that I do much of it anyway, but even further, put further walls in place and hurdles in place so I do than what I normally do (Lines 524-527).

Participants appear to exert conscious control over protecting themselves from difficult thoughts and feelings. Using the metaphor of 'walls' demonstrates Claire's strong intention to protect herself. It may be that Claire feels that not talking about her emotions prevents her from experiencing

them. This links to the next subtheme of 'the prevention of emotional expression'.

2.4.1.3 Subtheme: Prevention of emotional expression

In relation to avoidance of difficult thoughts and feelings, most of the participants describe how they also prevent emotional expression in response to difficult emotions. Ann appears to perceive not showing her feelings as a positive attribute:

Ann: well I don't think I show it outwardly. But I have been told that I do. Erm, I think that I'm quite good at not showing my feelings. But somebody will say, that I saw that the way your foot moved or something (laughs) or a (pause) so I think, I actually think I do it quite well but I don't think, from what people have feedback to me that I don't do it very well and its obvious what I feel (Lines 517-522).

It is interpreted that Ann perceives not showing her feelings as a skill that she is 'quite good at' or can 'do it quite well'. This leads one to question what the participants perceive to be the advantages and disadvantages of not expressing their emotions. Jane appears to be in conflict about expressing her emotions to others:

Jane: If I am feeling really stressed I don't think anybody would really notice. I hope they wouldn't. And they have never ever told me that oh you're looking particularly stressed today, and nobody would notice. I think that's my bad thing actually. Because I do bottle it up and I go home with it. That's what I do, that's what's really bad (Lines 631-635).

Although Jane hopes that no-one will notice her stress, she also recognises that not talking about her feelings may not be the most helpful strategy. She goes on to talk about remaining 'professional' (Line 644) in relation to not sharing her feelings, thus it is interpreted that Jane perceives emotional expression at work as being incompatible with being professional.

Across participants there seems to be a difference between showing and expressing emotion to others and talking to others about what is bothering them. For example Dawn uses the phrase 'not at all' (Lines 310 & 311) to describe the extent, to which she has 'no problems in telling my colleagues what I feel stressed about' (Lines 309-310). Whereas, Jane said 'I do say sometimes but you know, my attitude or emotions don't change' (Lines 646-648).

2.4.1.4 Subtheme: Social coping through colleagues

All seven participants talk about how they use their colleagues as a source of support, with most of them using this support to cope with difficult emotions. Talking with colleagues appears to serve different purposes amongst the sample. For example, Ruth described feeling validated by 'having somebody else acknowledge the feeling that you are having' (Lines 139-140), whilst Jane described feeling contained through reflecting with colleagues:

Jane: Just gives me reassurance really, just to say you know, if have I done the right thing? What would you have done? What shall I do now? And sometimes you know you can over catastrophise things can't you and say oh you know. This could happen or this could happen. But, you know they just give me a bit of reassurance and say what else can we do? (Lines 161-166).

Kate spoke about a reciprocal sharing of coping strategies within the team:

Kate: I don't think there is one size fits all, for everything or one size fits everybody so I think within a team we will share strategies. If something was having an impact on you and then you would because we do share within a team and you feel confident and able to share it (unclear) in detrimental ways. That's where you are and that's how

things are, so you could say to colleagues try this try that. Give them a while so, if you feel your own strategies that you have used before are a bit rusty, there's something new (Lines 852-859).

Social coping amongst colleagues seems to serve the function of containment and validation, with participants also benefiting from problem-focused practical advice that they provide each other with. Overall the superordinate theme 'response to difficult emotions' encompasses a range of strategies that participants engage with to cope with the emotions elicited by working in the crisis team. Although avoidant coping features amongst participants, they also approach their difficulties somewhat by seeking support from others.

2.4.2 Superordinate Theme 2: Impact on self

The theme of 'Impact on self' emerged from the analysis and is primarily concerned with how the nature of the work in the crisis team impacts on the clinicians' self-identities and continues to have an impact on the 'self' at home. All participants provided information to support the subthemes, which were 'self in relation to clients', 'self at work' and 'self at home'.

2.4.2.1 Subtheme: Self in relation to clients

All of the participants' narratives contained descriptions of positive experiences of their relationships with clients. Kate describes her role as a short-term helping hand within the client's life journey:

Kate: Yeah cause like when you work with a client and you're doing a programme of work. So you start at the beginning and you're kind of like, still in crisis but still at a stage when they actually able to take on board some strategies. And then when you watch a client grow, you kind of like you're walking a short way with a client, that's one of the joys of the job you're your actually spending a short time with a client on their journey. And it's kind of like handing over the baton really 'cause you're giving them skills and confidence to take control of their life. And it's a great feeling when they start taking it off you and they are going forward (Lines 225-235).

Here Kate describes the relationship with the client as collaborative in nature, giving the client the skills they need to feel empowered to which she describes experiencing a 'great feeling' when they are receptive.

Most participants also describe challenges in their relationships with clients. The meaning of these challenges seems to pertain to the nature of the client's difficulties and whether this has an impact on their ability to engage

in the work that is being offered. Therefore it is interpreted that participants make sense of the challenges in their relationships as the client's responsibility. Ruth describes some of her struggles in relationships with clients and like other participants, compares the difficulties working with clients who have different diagnoses:

Ruth: It is hard work sometimes when somebody is depressed really. The mania you can of course it's not pleasant for the person who is suffering it, but you can get on with it. Depression is sometimes trying to motivate somebody, trying to get them to do things is also frustrating, also difficult. 'Cause you don't seem to be progressing very, it's not as rewarding as you know other illnesses would be. 'Cause its so difficult and trying to push somebody and motivate them and get them to take medication and trying to change the viewpoint and doing CBA approach on them. It's a bit frustrating sometimes. I don't find them as frustrating as personality disorder. It is hard work (Lines 179-189).

Clinicians typically struggle when clients do not get better. Ruth describes this struggle as 'not as rewarding' which denotes a lack of satisfaction that she feels within herself as a result. As the clinicians seem to attribute the difficulties in progressing to the client and/or their illness, it is interpreted that these projections serve the function of protecting clinicians from feelings of

incompetence about themselves. Further evidence for this, is described in the next subtheme.

2.4.2.2 Subtheme: Self at work

All the participants talk about how the job makes them feel about themselves. There appears to be a theme of how the outcome of a particular piece of work can impact on feelings of self-worth and competence. Ann talks about the experience of receiving appreciation from clients when work has been a success:

Ann: Well you're feeling like you are doing a good job. You feel like you're not incompetent. You know, all the little messages that you get, it's kind of dispelled almost, and that almost giving you permission that, that's not true, you are competent and you are a nice person. So it makes you feel valued and you know erm, not needed but valued you know what you do is a good thing (Lines 654-668).

Here appreciation from others appears to bolster self-confidence and is used as evidence for being a nice person who is competent and of value. In support of the interpretation that self-worth is based on the outcome of a piece of work, Ann also describes feeling 'really dreadful' (Line 160) and 'not caring' (Line 161) if perceived as unhelpful by client's families.

Due to the nature of crisis team working it is not surprising that the fear of client suicide exists in participants' narratives. The decisions made by clinicians' are of critical importance to clients' lives. It is interpreted that the 'fear' of what client suicide would mean for the clinician has an impact on the process of making decisions. Dawn describes conducting a risk assessment of a client who is at risk of harming themselves:

Dawn: It's horrible, I mean we stood outside and we did the mental check about Coroner's court. If she kills herself tonight...(Lines 397-399).

It appears that Dawn questions whether the decision she has made would stand up in a coroner's court. It is suggested that the fear of what could happen to the clinicians leads them to question their competence in making decisions. Jane describes how this feeling of incompetence for her results in an over-reliance on the team manager:

Jane: Well that's what can make you feel really quite incompetent sometimes because if someone is making constant decisions for you because you are too scared to make the wrong decision, then you just it's easier just for somebody else to make the decision for you really. So, I just feel sometimes it's the decision making in our team is quite important, because if you make the wrong decision you don't know

what could happen. So but if your not getting practice at it, then you are never going to do it (Lines 688-695).

For Jane the reliance on others further feeds into feelings of incompetence the next time a decision is to be made. The use of the term 'wrong' decision appears to be based on whether or not the client harms themselves or commits suicide. It neglects the fact that the best decision may have been made at the time with the information available. It seems as though the outcome of the work is used to evaluate whether or not a good decision was made.

2.4.2.3 Subtheme: Self at home

All of the participants talked about how working in the crisis team has an impact on their home life. Most of the participants spoke about not being able to 'switch off' from their thoughts and feelings about work when they are at home (Claire, Line 138, Dawn, Line 292, Jane, Line 249, Kate, Line 135).

Dawn describes the physical sensations she experiences when she feels anxious, which continue when she gets home:

Dawn:...you sort of get that inner erm (pause) sort of inner buzz that, have it when you even get home even. How would I describe it? It's just really cannot switch off, it's just all churning, churning away,

churning away and either it's all got to be taken away or you need to explode (laughs) you know one or the other (lines 290-294).

Here Dawn recognises that something needs to change in order for her to feel better. It is tentatively interpreted that Dawn may experience this type of anxiety as unmanageable as her language suggests that the solution is that the feeling needs to be taken away as if by external sources or she needs to explode.

Participants also describe how they attempt to separate their work life and home life. For example Ann talks about making 'a real effort' so that work 'won't encroach' (Line 559) on her personal life. Whilst, Claire describes 'wanting to kick myself' (Lines 215-216) for 'not being able to make the separation between work and home life' (Lines 216-217). This attempted separation may link to the subtheme of self-protection discussed earlier. Despite clinician's efforts, it is interpreted that the experience of thoughts and feelings about work at home, is intrusive in nature. Kate uses the metaphor of a disobedient toddler to describe difficult thoughts and feelings she experiences in relation to work:

Kate: The situation is kind of like you know, but its going to keep coming back. You know you've put it to bed at 7 o'clock, but it's like the toddler, I won't sleep or I want to play, or I want to do this. It's kind of like...

Interviewer: And that's how you describe kind of the thoughts about work and ...

Kate: Yeah it's just yeah you can't put it to bed it just wants to intrude on your evening so to speak. And it pops in unexpectedly you know, watching a film and its just there (Lines 756-766).

In addition most of the participants talked about how thoughts and feelings about work can have an impact on their sleep. Some describe 'being kept up all night' worrying about their responsibilities at work (Jane, Line 182), whilst others described difficulties falling asleep, or waking up and thinking about work. Claire described experiencing 'very vivid disturbing nightmares' (Line 244) that she feels are in relation to work and 'dreams on occasion about the decisions' (Line 235) made at work.

In contrast, one participant talks about the positive effects the job has on the self at home. Rose is a relatively new member of the team and spoke about improvements in her home life as a result of working in a crisis team:

Rose: Now I find actually with shifts I have got time to do things that I would like to do because I don't have the mental fatigue as well, actually I have got the mental and the physical energy to do more stuff that I would like to do (Lines 721-724).

2.4.3 Superordinate Theme 3: Intergroup processes

Relationships with colleagues are important to the participant's emotional experience of working in the crisis team. This phenomenon may be intensified due to the team approach to crisis work involving shared caseloads and shared working.

2.4.3.1 Subtheme: Shared experience

All participants spoke about how their experiences within the crisis team were shared amongst their colleagues. Phrases like 'we're all in the same boat' (Claire, Line 451 & Jane, Line 670) and 'the camaraderie of it' (Dawn, Line 736) seem to reflect this. This is further exemplified by Kate's description of a shared emotional experience:

Kate: Satisfied that you have done a good job and it's not personal satisfaction it is team satisfaction as well as personal satisfaction. You know, I haven't got my little (laugh) superwomen hat and done it all myself, you know it is very much a team approach. So yeah, I'm sort of thinking yeah we do good (Line 350-354).

The use of the word 'we' features heavily throughout all of the transcripts when describing experiences and Ruth tells of how team behaviour can reflect the nature of a client's problem:

Ruth: We've decided in the team if you talk about a patient too many times, they've got personality disorder (laughs) (Lines 119-121).

This reflects a shared experience of clients. It is interpreted that difficulties in relation to clients are discussed among colleagues, which links to the subtheme 'social coping through colleagues'. Here Ruth is describing discussion that leads to further discussion perhaps when problems are not easily resolved. It is interpreted that clinicians may project these feelings of difficulty on to the client by jokingly diagnosing them with personality disorder. This links to the subtheme 'self in relation to clients' as discussed earlier.

2.4.3.2 Subtheme: Interpersonal difficulties

Despite using colleagues as a source of support and experiencing times of unity, most participants also identified times when they perceived themselves as different to their colleagues to the point of interpersonal difficulty. Frustration with colleagues appears to be a common theme amongst participants. During her interview, Ann displayed the strong emotion felt towards a colleague through the language she used:

Ann: O.k., erm we're a very small team and erm and the er [sigh] I feel terrible saying it ...there's one person in the team that I feel very irritable when I'm with and I feel ... shut the f*** up, 'cause sorry but you know (Lines 419-422).

It is interpreted that Ann initially struggles to articulate what she wants to say and feels 'terrible saying it'. This may be because of the strong emotion she experiences in relation to this subject which her language goes on to display. Later Ann spoke about how her emotions make this person 'difficult to work with' (Line 443). Ann told the interviewer that she would not express these emotions to her colleague due to the fear of 'conflict' (Line 456). This relates to the subtheme 'prevention of emotional expression'.

Ruth describes her anger at feeling betrayed by colleagues:

Ruth: Or you sometimes you know people get to the top by stepping on other peoples toes. That I find annoying, that makes me feel really angry and very ...(pause)... backstabbing and stuff like that, that I think is just wrong (Lines 971-974).

It is interpreted that Ruth may perceive some of her colleague's actions as underhand. Therefore, perhaps a lack of trust in others may feed into interpersonal difficulties amongst colleagues.

2.4.3.3 Subtheme: Emotional Contagion

Most of the participants in the sample described a phenomenon whereby the emotions of colleagues can be sensed in the atmosphere and have an impact on individual emotions, the team and the environment.

Kate alludes to the size of the team as an explanation for this phenomenon:

Kate: because we are such a small team you do pick up from other people. So if somebody is in a mood or somebody's tense in the office you are aware of that. So it does have an impact on the team (Lines 461-464).

Although most participants talked about engaging in ways to 'prevent emotional expression', it appears as though tension as a result of somebody else's mood can be sensed in the office environment. Therefore, although clinicians may not be actively expressing their emotions they can have an impact on those around them. Claire comments on the wide ranging impact of a colleague's mood:

Claire: when she comes in and is on bad form, that can really make for a, you can have the nicest shift and she comes in on bad form and that just really, the whole air of tension about the place she can actually physically palpate the tension in the room. And it doesn't make for a particularly great working environment (Lines 615-620). So that can make for a very uncomfortable, very stressful eight hours...if not longer (Lines 623-625).

Claire describes how the 'nicest shift' can turn into a 'very stressful eight hours' as a result of a colleagues mood. It is interpreted that this appears to be a very 'powerful' (Kate, Line 580) phenomenon as it is able to elicit 'stressful' feelings amongst colleagues.

2.5 Discussion

2.5.1 Summary of Findings

This study aimed to explore the emotional experiences of clinicians working in a Crisis Team. Analysis using IPA revealed three superordinate themes: 'Response to difficult emotions', 'Impact on self' and 'Intergroup processes'. These will now be explored with the study's aims in mind and in the context of the existing literature.

2.5.2 Consideration of findings

2.5.2.1 Emotional Experiences

The first research question asked ‘What are the clinician’s emotional experiences of working in a crisis team?’ A range of emotional experiences were described across the interviews which included anxiety for client safety in relation to the decision making process and frustration associated with colleagues and the inability to be helpful to clients. These emotional experiences are woven into the narratives across the themes and do not pertain solely to any one of the main themes.

The fact that the analysis did not draw out emotions or emotional experience as a main theme is unexpected. As is the lack of discussion by participants about their reactions and emotional responses to the suicide of clients, given that much of the focus of the work in crisis teams is to prevent such incidents. It may be useful to think here about why this may be.

Although participants did speak about their emotional experiences their descriptions appeared to lack depth. Participants described using avoidant coping strategies to manage their emotions which were interpreted in this study to be a defence against difficult emotions. ‘Defence mechanism’ is a term usually associated with psychodynamic theory. It is used to describe a process that a person engages in, to protect themselves from perceived painful emotional states (Lemma, 2003), that if consciously acknowledged

would be too difficult to bear (Bateman, Brown and Pedder, 2000). Therefore employing defense mechanisms helps people to maintain a sense of personal coherence (Leiper, 2006). The existence of avoidant coping in participants suggests that there is something to avoid. It is hypothesised that participants in this study have strong emotional reactions which are triggered as a result of working in the crisis team, however due to their overwhelming nature they are not experienced fully or shared with others. Therefore it is suggested that 'emotional experience' was not found to be a main theme for this reason. Avoidance as a generic way of coping will be discussed further in response to the next research question.

2.5.2.2 Coping with emotions

The second research question asked 'How do crisis team clinicians cope with the emotions they experience?' All participants talked about their 'Response to difficult emotion' in relation to working in the crisis team. The subthemes 'self-protection' and 'prevention of emotional expression' relate to how the participants attempted to avoid experiencing difficult emotions as a way of coping, as discussed above. This is consistent with ways of coping found in some studies of mental health workers (Ingledew, Hardy & Cooper, 1997) and has been associated with negative outcomes such as burnout (Thorton, 1992).

Crisis teams are in a unique position in that they share characteristics with both community-based mental health teams and emergency services. Therefore, drawing on the coping literature of emergency services professionals may be helpful in understanding further how crisis team professionals cope. Avoidant coping styles have also been found amongst emergency workers. The research on emergency workers reports significant positive relationships between avoidant coping and both psychological stress symptoms (Wastell, 2002) and traumatic stress symptoms (Holland, 2007).

In addition to avoidant coping, the findings from this study suggest that clinicians also engage in behaviours that 'transform emotions to self soothe' as a way of coping. This relates to emotion-focused coping, which is the attempt to regulate difficult emotions that are part of the experience of stress (Lazarus and Folkman, 1984). Attempts to regulate emotion have previously been identified as a way of coping amongst crisis team clinicians (Freeman et al. 2011). Although the literature on stress management in mental health professionals suggests that the removal of stressors (problem-focused coping) is the most effective way of managing work place stress (Edwards, et al., 2002), problem focused coping may not always be the most efficient way of coping with emergency situations (Cicognani, Pietrantonio, Palestini & Prati, 2009). Emotion-focused coping has been found to be associated with lower levels of psychological distress in emergency workers where there are lower levels of exposure to trauma (Brown, Mulher & Joseph, 2002).

Participants also engaged in 'social coping through colleagues' which manifested itself through talking to colleagues. This appeared to help clinicians feel contained and validated. This finding is consistent with other studies of clinicians involved in crisis care who describe drawing on the resources in the team for support to manage job stress (Freeman et al. 2011) and perceiving the team to be a protective factor against stress (Edward, 2005). In addition the use of 'social coping through colleagues' is a common coping strategy used amongst mental health professionals (Edwards & Burnard, 2003, Reid et al., 1999) and therefore is consistent with the literature on stress and coping.

2.5.2.3 Personal and professional impact of experience

The third research question asked 'How do work related emotions impact clinician's personally and professionally?' Participants described how the nature of work that they are exposed to in a crisis team has an impact on how they feel about themselves both personally and professionally.

Relationships with clients were experienced as positive when clients were able to engage in skills that the clinician could offer and when a piece of work has been helpful to the client. This made the clinicians feel good about themselves and in some cases bolstered feelings of competence. This relates to the concept of 'Compassion Satisfaction' which describes the

feelings of pleasure in helping others through work and having confidence in individual and colleagues abilities to contribute to the work setting and society as a whole (Stamm, 2010). A recent study of emergency workers found that 'compassion satisfaction' was strongly associated with self-efficacy, which appears to be consistent with the findings of this study (Cicognani et al., 2009).

Challenging experiences with clients appeared to be based on both the nature of the client's difficulties and how such difficulties impacted upon the clinician's ability to facilitate change. Some participants identified people with personality disorder as more difficult to work with than other clients which is consistent with other findings amongst psychiatric nurses (Markham, 2003). Crisis team clinicians have also been found to hold negative attitudes towards clients with personality disorder (Purves, 2009). It has been suggested that negative experiences of patients with personality disorder can be mainly attributed to clinicians feeling unable to help effectively (Woollaston & Hixenbaugh, 2008), which relates to the interpretations in this study.

Helping clients to facilitate change was also found to be a stressor in another study of crisis team clinicians (Freeman et al., 2011). However, in contrast clinicians in this study highlighted their disappointment with service providers

when clients were re-referred to the crisis team rather than the difficulties of the client.

The fear of how a client suicide would affect clinicians appeared to influence the way they made decisions, and the level of competence felt in their decision making abilities. Professional self-doubt has been found elsewhere to be a common stressor amongst psychiatric nurses, with self-esteem being found to be one of the main protective factors in managing work stress (Edwards & Burnard, 2003).

This study also found that the effects from work can be experienced in the clinician's personal life at home. It is suggested here that the inability to 'switch off' from work and the intrusive nature of thoughts and feelings at home could be related to unprocessed emotion as a result of avoidant coping. Previous literature has investigated work-home conflict among community psychiatric nurses and similarly found themes of 'spill over and contagion' to describe continued feelings from work at home (Majomi, Brown & Crawford, 2003, Hopkinson, Carson, Brown, Fagin, Barlett, & Leary, 1998).

Relationships with colleagues were found to be of particular importance to the participants within this study. Shared experience as a phenomenon was described as supportive in nature and relates to the findings of Nelson et al.

(2009), who reported team work as a source of satisfaction in crisis team professionals and suggested that it may be helpful in reducing stress. Participants also described 'interpersonal difficulties' with their crisis team colleagues as a source of frustration. Interpersonal difficulties were also found to be a stressor in another study of crisis team clinicians (Freeman et al (2011), however these difficulties were with professionals outside of the crisis team. Such difficulties were also found to be a common source of stress in a review of mental health nurses (Edwards and Burnard, 2003). The participant's narratives in the current study indicated that they were unlikely to express their frustrations to their colleagues which may prolong these difficulties. This finding is consistent with Nelson et al. (2009), who found poor communication with colleagues to be a source of stress in crisis team clinicians.

Emotional contagion is a term used to describe a 'process in which a person or group influences the emotions or behaviour of another person or group through the conscious or unconscious induction of emotion states and behavioural attitudes' (Schoenewolf, 1990, as cited in Barsade, 2002, p. 50). Participants' descriptions of how a colleague's mood can impact on the team appear to fit with this phenomenon. Most research on this concept lies within the literature on organisational behaviour. However, one study found that after controlling for shared work problems, the moods of teams of nurses were related (Totterdell, 1998). This finding appears tentative and offers very

little to understanding emotional contagion in mental health teams. In the current study this phenomenon impacted on clinicians' stress levels and their ability to work with others. Thus, it is likely to impact on their work.

Understanding the emotions of mental health practitioners within teams, demonstrated in this way appears to be a relatively novel finding amongst the mental health literature.

2.5.3 Implications for clinical practice

The findings from this study offer new insights and important contributions to understanding emotional experience and its impact on the practice of clinicians working in Crisis Teams within the UK and perhaps beyond. The findings suggest that clinicians are likely to use avoidant coping strategies to manage their difficult emotions associated with work, which have been associated with more negative outcomes for clinicians elsewhere. Therefore it would be helpful for clinicians to be supported in finding new ways of coping which have more positive outcomes. More effective coping strategies may have a positive impact on the clinician's personal life which may improve their work-life balance.

Engaging in team reflective practice to encourage self-awareness and communication of feelings may be helpful. This would hopefully provide a safe place for clinicians to talk about their struggles in relation to work where they can feel validated and contained, which may build resilience to

experiencing difficult emotions. The introduction of activities such as reflective practice would need to be considered carefully to meet the needs of the staff group. Defence mechanisms such as avoidance often exist to maintain personal coherence, therefore any intervention that may change the way clinicians manage emotions should be approached with caution.

Peer support and shared aspects of experience was found to positively benefit the experience of crisis team clinicians, whereas interpersonal difficulties and the impact of colleagues emotions on each other was found to have a negative impact on team functioning. Therefore, emotional peer support should be encouraged, the importance of shared experience highlighted and clearer communication about difficulties within the team sensitively managed. In addition, crisis teams may benefit from emotionally aware managers and supervisors who can recognise emotional difficulties in individual clinicians and within team relationships and implement support accordingly. Support in these areas may improve team cohesion and have a positive impact on the clients under their care.

This study suggests that the fear of being unhelpful and the fear of the client committing suicide is detrimental to the clinicians' feelings about themselves and their professional competence. Building belief and confidence in decision making abilities may be helpful to the emotional experience of staff

and should be an important part of post suicide support after any investigation.

2.5.4 Methodological considerations and limitations

Grounded theory is often the main alternative method considered, when deciding to use IPA. IPA however, offers a more detailed analysis of lived experience than Grounded theory, which aims to develop a conceptual explanation (Smith et al., 2009). IPA was chosen as the preferred method in this instance because the study aims to understand the essence of experience for a lived phenomenon rather than developing a theory (Cresswell, 2007).

IPA is limited in that it relies on the language participants use to communicate their experience. It can be argued that language reflects how an individual talks about experience rather than the experience itself. Alternatively, it could be argued that language 'provides the categories of experience' and that as a result 'precedes and therefore shapes experience' (Willig, 2001, p. 63).

Due the interpretative nature of IPA, the analysis and therefore the outcomes of the study are likely to be influenced by the researcher's own biases. In IPA such biases are perceived as necessary to make sense of another

person's experience. However, it is important to acknowledge that the results of this study are based on the author's interpretation of the participants' accounts.

The results of this study should be considered in light of the study's limitations. The findings are based on the experiences of seven clinicians working within one Crisis Team. Professionally the sample was made up of six psychiatric nurses and one occupational therapist. The exclusion criteria meant that psychologists, psychiatrists, managerial and administrative staff were excluded from taking part in the study. Although this study is enriched by focusing on the experiences of front-line clinicians, it lacks contributions from clinicians involved in wider crisis team working. In addition, all the participants were qualified clinicians, with two unqualified clinicians not volunteering to take part. It is not known from this how similar or different the experiences of unqualified staff are.

2.5.5 Recommendations for future research

To the researcher's knowledge this is the first study to explore clinicians' emotional experiences and coping responses to working in a UK crisis team. Therefore further research in this area would help to further place the findings of this study in context, leading to a better understanding of how the experience is similar or different to those working in other community mental health teams or emergency services.

Further research regarding the sense of competence experienced by clinicians, who make decisions where there is a risk of patient suicide is needed. Knowledge of how feelings of competence impact on the decision making process and patient care may help to understand how such processes can be improved.

Further investigation of the phenomenon of emotional contagion in mental health professionals and teams and the potential impact this has on patient care is warranted. The emotional experience of members of the wider crisis team (i.e. managers, psychiatrists, psychologists) and how their experiences relate to those of front line staff would shed further light on the findings of this study.

2.5.6 Conclusion

This study highlights the issues that are important to clinician's experiences of working in a crisis team. In this study clinicians appeared to lack confidence in making risk decisions, for fear of how the consequences of a client suicide would have an impact on them. Clinicians typically struggled when they felt that they were unable to help clients and responded to their difficult emotions by engaging in avoidant coping. This avoidance is likely to have left emotions unprocessed, which may give some explanation of the continuation of feelings from work at home. The shared experience of being

part of a team and seeking support from colleagues was helpful to clinicians in managing some of their anxieties. However, team work was also a source of stress, influenced by interpersonal difficulties and colleagues emotions. Further understanding of crisis team clinicians experience would be beneficial; as would support for clinicians to build their confidence and resilience to working in such a team. This is likely to have a positive impact on clinicians' well-being and in turn patient care.

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Chapter 3: Reflective Paper

Personal reflections on researching the experiences of mental health professionals

3.1 Introduction

This paper provides a personal reflection on the emotional journey which accompanied the research process. Given that the research focused on the emotional experiences and coping of mental health professionals, it seems appropriate for this reflective paper to focus on my own emotional experience and coping in relation to the research process. It includes reflections about the impact of exploring the issue of suicide and the use of qualitative methodology. It also includes reflections on the parallel process between my own experiences and those of research participants. Finally, it concludes by reflecting on the influence of my learning on my future practice.

3.2 Emotional impact of the research process

Uncovering the personal and professional impact of patient suicide and of working in a crisis team, were the primary aims of my research papers. Reflecting on the research process, I have found that conducting this study has had a personal and professional impact on me.

3.2.1 Exploring the issue of suicide

In designing and finally carrying out the literature review, I was surprised to discover the wide ranging effects that patient suicide can have on mental health professionals. Although not the focus of my review I was also

surprised at the frequency of patient suicides, with researchers describing it as an 'inevitable incident' (Midence, Gregory & Stanley, 1996, p.115) and 'an occupational hazard' (Chemtob, Bauer, Hamada, Pelowski & Muraoka, 1989). Reflecting on these findings has elicited thoughts about my own future career and led me to question how I or the colleagues around me might cope with such an event. These questions were accompanied by feelings of fear and dread at the prospect of it. Although anxiety-provoking for the reasons just mentioned, the process of conducting the review has acutely raised my awareness of such issues. Fortunately the investigation into how professionals cope, considering areas for future research and how findings can be implemented into practice has brought me some comfort. It is hoped that with the right support, tailored to the needs of the professional, adverse emotional effects of patient suicide may be reduced.

3.2.2 Stepping into the participants shoes

In terms of the empirical paper, I have found using Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009) a fascinating process both conceptually and experientially. Being new to IPA I was excited by the active role the researcher plays within the whole process. In IPA the researcher engages with the participants account in a reflective way in order to make-sense of participants making sense of their own experience, which is a phenomenon known as double hermeneutic (Smith et al., 2009). In order to interpret the participant's experience there is a need for

the researcher to 'understand what it is like to stand in the shoes of the participant whilst recognising this is never completely possible' (Smith and Eatough, 2006, p. 324). Although exciting, the qualitative approach chosen also had its challenges.

As with the analysis and interpretation of data, attempting to step into the participants shoes was also a feature of the research interviews.

Empathising with participants as part of the qualitative interviews was a key process in building rapport (Watts, 2008). The personal impact however of connecting with participants' stories was unexpected. Following many of the interviews, I often came away feeling tired and drained of energy. It would take me a while to 'switch off' from the interviews or as it felt 'switch back on'. Initially I thought this may be because I had been planning this research project over many months and was apprehensive about potential hurdles with recruitment and data collection. Reflecting on my feelings and the emerging data, I began to wonder whether the feelings I was experiencing were in part a reflection of what the participants' themselves were feeling.

For example, I was able to identify with one participant's feelings of flatness following some of the interviews:

Claire: So it has on occasions I just feel I can feel, after a shift I can feel emotionally, like I've been flattened by a rollercoaster and I just, I

nearly feel emotionless so I do. Just that I have been nearly robbed of, sucked, the emotions have been sucked out of me (Lines 673-677).

In psychodynamic psychotherapy the term 'concordant counter-transference' is used to describe when a therapist empathises with and experiences the client's emotional position, thus feeling as they do (Ursano, Sonnenberg, & Lazar, 2004). This may offer some explanation for my feelings in relation to the research interviews.

The feelings I was left with following one research interview in particular stand out in my mind. This was the interview with Kate who recounted her experience of patient suicide. I remember feeling overwhelmed and saddened by what she had told me and I feel that my continued experience of those feelings after the interview had finished reflected Kate's experience i.e. 'the residue is always going to be there' (Kate, Lines 906-907). This continuation of feelings also links to the superordinate theme found across the data in the empirical study of 'Self at home'.

It has been suggested that in an approach where data emerges out of a dialogical encounter between the researcher and participant there is a need to be aware of the unconscious processes being re-enacted within the relationship (Finlay, 2009). I feel that being aware in this way may help to

understand the participants experience further, but also help the researcher to bracket off their own feelings from the experience of the participant. To allow the participants experience to be in focus, the researcher needs to avoid pre-occupation with their own experience (Giorgi, 1994). I feel that being a novice in IPA, I followed the guidelines (Smith et al, 2009) closely and attempted to have an awareness of this potential problem throughout.

3.3 Parallel Process

Reflecting on the research process as a whole, I have noticed some parallels between both the emotional experiences and coping mechanisms in participants and within myself.

3.3.1 Self-doubt

Overall I have found the research process intellectually and emotionally challenging. At the beginning of the process I remember feeling overwhelmed with the many interests and ideas that I had in terms of what to focus on. I worried about choosing the 'right' topic, not wanting to miss out on where my research interests lay. In the initial stages academic supervision was crucial in containing my anxieties and shaping my research ideas into research questions. Later in the process I sometimes struggled with decisions such as the inclusion and exclusion criteria for papers in the literature review and the process of settling on master themes and selecting quotes to best represent them, in the empirical paper. I knew that although I

was making decisions informed by the information I had, that whatever I decided would affect the outcome of the research. The process I experienced here appears to reflect some of the experiences of participants as described in the two main research papers. For example crisis team clinicians appeared to struggle with the decision making process due to the feared consequences of their decisions, whilst a theme from the literature review was that participants doubted their own abilities in relation to work following patient suicide. Acknowledgement and containment of the emotional process by managers was among the recommended clinical implications for both of these research papers, which perhaps parallels the supervision I received on my research journey which I found helpful.

3.3.2 Coping

The conflicting demands of the clinical psychology doctorate course include completing clinical placements alongside research commitments. Therefore time management is of great importance. Juggling the various demands was accompanied by fluctuating feelings of frustration, self-doubt and a sense of being overwhelmed. At times I felt that these emotional experiences prevented me from progressing with the research in the ideal way I had envisaged. As a response to these emotions I sometimes found myself thinking 'if I could just separate my emotions from my work then I could continue with it in a productive way'. At the time, I was aware that this was an avoidant way of thinking about my emotional experience and through

reflecting on my feelings and engaging in healthy ways of coping I was able to continue with the research with more creativity.

Avoidance of emotions was also reflected in the narratives of the participants in the empirical study. In this study it was interpreted that the participants protected themselves from their own emotions so they could continue with their work in a crisis team. Avoidance was a less evident theme in the results of the literature review; however a few studies did report small numbers of clinicians avoiding suicidal patients and cues that reminded them of the patient suicide.

At times during the research process, I also found myself getting caught up in the more minor details of the research. Although important, this may have served as a distraction from the overwhelming nature of the more critical aspects of the research process. Members of the crisis team in my empirical study spent a lot of time talking about their colleagues during the interviews. Although their experience of their colleagues held importance for them, it could be speculated that this too served as a distraction from their own feelings about working with difficult clients.

As this process has been challenging, it has given me the opportunity to learn more about ways of coping that work best for me at different times. In contrast to the participants in the empirical study, I feel that I have been

aware of the importance of expressing my emotions. At times being a researcher can feel like being a lone ranger, therefore sharing my feelings with others has been important.

In addition to supervision, engaging in peer support with fellow researchers also completing the clinical psychology doctorate has been invaluable. Being able to share both emotional experiences and methodological understandings has facilitated feelings of validation and helped me to stay grounded. Again, I feel this reflects the strategies that the research participants in both the literature review and the empirical study engaged in as a way of coping with their experience. Colleague support was reported to be the most commonly sought and most helpful source of support following patient suicide across the studies in the literature review and 'social coping through colleagues' was a subtheme in the empirical research.

3.2.3 Positive feelings

I also experienced pleasurable feelings as part of the research process. These included initial feelings of curiosity about what I may uncover and excitement about the prospect of my research contributing to the evidence base and to clinical practice. As the research process continued I often felt a sense of achievement, particularly in relation to reaching smaller milestones throughout the process. For example, deciding on the final papers that met the criteria for the literature review, completing data collection, finally

finishing the transcription of interviews and completing drafts of the write up. As the research continued to take shape, I felt pleased as I began to see the real value of the research project and how it could contribute to positive change in clinical practice. During the final stages I also experienced feelings of relief and accomplishment, as the research began to come together as a whole. Parallel to this the participants in the empirical study often described feeling good about themselves when the consequences of their work had a positive outcome. They also described feeling relieved when the clinical decisions they had made did not lead to adverse consequences.

3.3 Clinical utility of new learning

Reflecting on the findings and the process of the research led me to question how I personally as a qualified clinical psychologist could use what I have learnt to support my future practice. Although the findings from the research can only be used to draw tentative conclusions due to the methodological limitations of the studies included in the literature review and the interpretative nature of the empirical study, they can be used to inform future research and to some extent practice.

Dissemination of the findings is one way to raise awareness of the results. I aim to do this through the publication of the main research papers and communicating the findings to mental health professionals who the issues are likely to affect including those working in crisis teams. Feelings of being

blamed for patient suicide appeared to complicate the process of coping for mental health professionals. Therefore, disseminating the findings of the research may also help in the shift from a feeling of stigma to a feeling of being understood and supported in the event of a patient suicide.

Conducting this piece of research has raised my awareness of the emotional reactions and needs of mental health professionals who have experienced patient suicide and work with clients in crisis. I envisage that this new knowledge will be helpful to me when providing clinical supervision to colleagues as a qualified clinical psychologist. In terms of crisis team working, I have learnt that clinicians are likely to experience anxiety in relation to decision making and may use some avoidant coping strategies to manage their difficult emotions. In terms of patient suicide, I have learnt that professionals may particularly struggle with feelings of guilt and sadness. Although supervision was not presented as a main theme in the empirical paper, many of the participants valued the supervision provided by the team psychologist to help them reflect on their emotions and relationships with colleagues at work. Supervision was also highlighted as helpful following patient suicide by some of the studies in the literature review.

The research has also raised my awareness of how team dynamics and group processes can both help and hinder the experience of team working, which may in turn have an impact on the working environment and

potentially the care provided to clients. Considering the importance of these factors when working with teams will be valuable to me in my role as a psychologist.

This process has led me to think about my own resilience when experiencing the pressure of competing demands and personal challenges. I have been able to reflect on the helpfulness of my own coping resources. This will help me to face the challenges that my future career is likely to produce and will have a positive impact on my relationships with others in my role as therapist, researcher or team member.

Although challenging, my confidence in my research skills has grown during this process as has my enthusiasm for engaging in research to inform evidence based practice.

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Please write your text in good English (American or British usage is accepted, but not a mixture of these). Authors who require information about language editing and copyediting services pre- and post-submission please visit <http://webshop.elsevier.com/languageservices> or our customer support site at <http://support.elsevier.com> for more information.

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Submission to this journal occurs online and you will be guided step by step through the creation and uploading of your files. Please submit your article via <http://ees.elsevier.com/ssm>. The system automatically converts source files to a single PDF file of the article, which is used in the peer-review process. Please note that even though manuscript source files are converted to PDF files at submission for the review process, these source files are needed for further processing after acceptance. All correspondence, including notification of the Editor's decision and requests for revision, takes place by e-mail.

Reviewers

During submission you will be asked if you wish to suggest the names and email addresses of potential reviewers. Note that the editor retains the sole right to decide whether or not the suggested reviewers are used.

Additional Information

Please note author information is entered into the online editorial system (EES) during submission and must *not* be included in the manuscript itself.

Social Science & Medicine does not normally list more than six authors to a paper, and special justification must be provided for doing so. Further information on criteria for authorship can be found in *Social Science & Medicine*, 2007, 64(1), 1-4.

Authors should approach the Managing Editor if they wish to submit companion articles. Information about our peer-review policy can be found [here](#).

Please note that we may suggest accepted papers for legal review if it is deemed necessary.

PREPARATION

Use of word processing software

We accept most word processing formats, but MSWord files are preferred. All author-identifying text such as title pages and references must be removed. Submissions should be double spaced and use between 10 and 12pt font, and any track changes must be removed.

It is important that the file be saved in the native format of the original wordprocessor used. The text should be in single-column format. Keep the layout of the text as simple as possible. Most formatting styles will be removed and replaced during

typesetting. In particular do not use the wordprocessor's options to justify or to hyphenate words. However, do use bold face, italics, subscripts, superscripts etc. Do not embed "graphically designed" equations or tables, but prepare these using the wordprocessor's facility. When preparing tables, if you are using a table grid, use only one grid for each individual table and not a grid for each row. If no grid is used, use tabs, not spaces, to align columns. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Guide to Publishing with Elsevier:

<http://www.elsevier.com/guidepublication>). Do not import the figures into the text file but, instead, indicate their approximate locations directly in the electronic text and on the manuscript. See also the section on [Electronic artwork](#).

To avoid unnecessary errors you are strongly advised to use the 'spell-check' and 'grammar-check' functions on your wordprocessor. The editors reserve the right to adjust style to certain standards of uniformity.

Authors should retain an electronic copy of their manuscript.

Essential cover page information

The Cover Page should **only** include the following information:

- **Title.** Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible and make clear the article's aim and health relevance.

- **Author names and affiliations in the correct order.** Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript

letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name and, if available, the e-mail address of each author.

- **Corresponding author.** Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. **Ensure that telephone and fax numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address. Contact details must be kept up to date by the corresponding author.**

- **Present/permanent address.** If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

- **Any acknowledgements** Include if appropriate. These should be as brief as possible and not appear anywhere else in the paper.

Text

In the main body of the submitted manuscript this order should be followed: abstract, main text, references, appendix, figure captions, tables and figures. Do not place tables and figures in the main text. Author details, keywords and acknowledgements are entered separately during the online submission process, as is the abstract, though this is to be included in the manuscript as well. During submission authors are asked to provide a word count; this is to include ALL text, including that in tables, figures, references etc.

Title

Please consider the title very carefully, as these are often used in information-retrieval systems. Please use a concise and informative title (avoiding abbreviations where possible). Make sure that the health or healthcare focus is clear.

Abstract

An abstract of up to 300 words must be included in the submitted manuscript. An abstract is often presented separately from the article, so it must be able to stand alone. It should state briefly and clearly the purpose and setting of the research, the principal findings and major conclusions, and the paper's contribution to knowledge. For empirical papers the country/countries/locations of the study should be clearly stated, as should the methods and nature of the sample, the dates, and a summary of the findings/conclusion. Please note that excessive statistical details should be avoided, abbreviations/acronyms used only if essential or firmly established, and that the abstract should not be structured into subsections. Any references cited in the abstract must be given in full at the end of the abstract.

Research highlights

Research highlights are a short collection of 3 to 5 bullet points that convey an article's **unique contribution to knowledge** and are placed online with the final article. We allow 125 characters per bullet point including spaces. They should be supplied as a separate file in the online submission system (further instructions will be provided there). You should pay very close attention to the formulation of the Research Highlights for your article. Make sure that they are **clear, concise and capture the reader's attention**. If your research highlights do not meet these criteria we may need to return your article to you leading to a delay in the review process.

Keywords

Up to 8 keywords are entered separately into the online editorial system during submission, and should accurately reflect the content of the article. Again abbreviations/acronyms should be used only if essential or firmly established. For empirical papers the country/countries/locations of the research should be

included. The keywords will be used for indexing purposes.

Methods

Authors of empirical papers are expected to provide full details of the research methods used, including study location(s), sampling procedures, the date(s) when data were collected, research instruments, and techniques of data analysis. Specific guidance on the reporting of qualitative studies are provided [here](#).

Footnotes

Endnotes and footnotes should not be used and any such information incorporated into the main text. If unavoidable a very small number of endnotes can be listed separately at the end of the text. These should be identified with superscript Arabic numbers.

Figure captions

Ensure that each illustration has a caption. Supply captions separately, not attached to the figure. A caption should comprise a brief title (**not** on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

Tables

Number tables consecutively in accordance with their appearance in the text. Place footnotes to tables below the table body and indicate them with superscript lowercase letters. Avoid vertical rules. Be sparing in the use of tables and ensure that the data presented in tables do not duplicate results described elsewhere in the article.

References

Citation in text

Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full at the end of the abstract. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal (see below) and should include a substitution of the publication date with either "Unpublished results" or "Personal communication" Citation of a reference as "in press" implies that the item has been accepted for publication.

Web references

As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

References in special issue articles, commentaries and responses to commentaries

Please ensure that the words 'this issue' are added to any references in the reference list (and any citations in the text) to other articles which are referred to in the same issue.

Reference management software

This journal has standard templates available in key reference management packages EndNote (<http://www.endnote.com/support/enstyles.asp>) and Reference Manager (<http://refman.com/support/rmstyles.asp>). Using plug-ins to wordprocessing packages, authors only need to select the appropriate journal template when preparing their article and the list of references and citations to these will be formatted according to the journal style which is described below.

The current *Social Science & Medicine* EndNote file can be directly accessed by clicking [here](#).

Reference style

All publications cited in the text should be presented in a list of references following the text of the manuscript. In the text refer to the author's name (without initials) and year of publication e.g. "Since Peterson (1993) has shown that..." or "...as claimed elsewhere (Kramer, 1994)". For more than 2 authors the first author's name and "et al." should be used e.g. (Annandale et al., 1994). The manuscript should be carefully checked to ensure that the spelling of authors' names and dates are exactly the same in the text as in the reference list. Responsibility for the accuracy of bibliographic citation lies entirely with the author(s). Authors are also responsible for the accuracy of the content of the references.

References should be given in the following form:

Annandale, E., & Hunt, K. (1998) Accounts of disagreements with doctors. *Social Science & Medicine*, 46(1), 119-129.

Macintyre, S., & Ellaway, A. (2000). Ecological approaches: Rediscovering the role of the physical and social environment. In L.F. Berkman, & I. Kawachi (Eds.), *Social epidemiology* (pp. 332-348). New York: Oxford University Press.

Blaxter, M.
(2010). *Health*.
London: Polity.

The current *Social Science & Medicine* EndNote file can be directly accessed by clicking [here](#).

Guidelines for Qualitative Papers

There is no one qualitative method, but rather a number of research approaches which fall under the umbrella of 'qualitative methods'. The various social science disciplines tend to have different conventions on best practice in qualitative research. However SS&M has prepared the following general guidance for the writing and assessment of papers which present qualitative data (either alone or in combination with quantitative methods). General principles of good practice for all research will also apply.

Fitness for purpose

Are the methods of the research appropriate to the nature of the question(s) being asked, i.e.

- Does the research seek to understand social processes or social structures &/or to illuminate subjective experiences or meanings?
- Are the settings, groups or individuals being examined of a type which cannot be pre-selected, or the possible outcomes not specified (or hypothesised) in advance?

Methodology and methods

- All papers must include a dedicated methods section which specifies, as appropriate, the sample recruitment strategy, sample size, and analytical strategy.

Principles of selection

Qualitative research is often based on or includes non-probability sampling. The unit(s) of research may include one or a combination of people, events, institutions, samples of natural behaviour, conversations, written and visual material, etc.

- The selection of these should be theoretically justified e.g. it should be made clear how respondents were selected
- There should be a rationale for the sources of the data (e.g. respondents/participants, settings, documents)
- Consideration should be given to whether the sources of data (e.g. people, organisations, documents) were unusual in some important way
- Any limitations of the data should be discussed (such as non response, refusal to take part)

The research process

In most papers there should be consideration of

- The access process
- How data were collected and recorded
- Who collected the data
- When the data were collected
- How the research was explained to respondents/participants

Research ethics

- Details of formal ethical approval (i.e. IRB, Research Ethics Committee) should be stated in the main body of the paper. If authors were not required to obtain ethical approval (as is the case in some countries) or unable to obtain ethical approval (as sometimes occurs in resource-poor settings) they should explain this. Please anonymise this information as appropriate in the manuscript, and give the information when asked during submission.
- Procedures for securing informed consent should be provided

Any ethical concerns that arose during the research should be discussed.

Analysis

The process of analysis should be made as transparent as possible (notwithstanding the conceptual and theoretical creativity that typically characterises qualitative research). For example

- How was the analysis conducted
 - How were themes, concepts and categories generated from the data
 - Whether analysis was computer assisted (and, if so, how)
 - Who was involved in the analysis and in what manner
- Assurance of analytic rigour. For example
 - Steps taken to guard against selectivity in the use of data
 - Triangulation
 - Inter-rater reliability
 - Member and expert checking
 - The researcher's own position should clearly be stated. For example, have they examined their own role, possible bias, and influence on the research (reflexivity)?

Presentation of findings

Consideration of context

The research should be clearly contextualised. For example

- Relevant information about the settings and respondents/participants should be supplied
- The phenomena under study should be integrated into their social context (rather than being abstracted or de-contextualised)
- Any particular/unique influences should be identified and discussed

Presentation of data:

- Quotations, field notes, and other data where appropriate should be identified in a way which enables the reader to judge the range of evidence being used
- Distinctions between the data and their interpretation should be clear
- The iteration between data and explanations of the data (theory generation) should be clear
- Sufficient original evidence should be presented to satisfy the reader of the relationship between the evidence and the conclusions (validity)
- There should be adequate consideration of cases or evidence which might refute the conclusions

Amended February 2010

Appendix C: Confirmation of Coventry University ethical approval

TO WHOM IT MAY CONCERN

RRU/Ethics/Sponsorlet

30 August 2012

Dear Sir/Madam

Researcher's name: Miss Helena Young
Project Title: Experiences of working in a crisis team: Exploring emotional coping using Interpretative Phenomenological Analysis

The above named has successfully completed the Coventry University Ethical Approval process for her project to proceed.

I should like to confirm that Coventry University is happy to act as the sole sponsor for this applicant and attach details of our Public Liability Insurance documentation.

With kind regards

Yours faithfully

Professor Ian Marshall
Deputy Vice-Chancellor, Academic

Enc

Confirmation of Coventry University ethical approval continued

REGISTRY RESEARCH UNIT
ETHICS REVIEW FEEDBACK FORM
(Review feedback should be completed within 10 working days)

Name of applicant: Helena Young **Faculty/School/Department:**
HLS/Clinical Psychology

Research project title: Experiences of Working in a Crisis Team: Exploring Emotional Coping using
Interpretative Phenomenological Analysis

Comments by the reviewer

<p>1. Evaluation of the ethics of the proposal:</p> <p>This is a well-considered and potentially very useful project. Recruitment of participants has been considered and addressed appropriately, as have issues of confidentiality & anonymity. Recruitment has however been confined to one local team; might it be useful to identify a back-up plan at this stage and an additional team considered?</p> <p>The potential for causing distress has been recognised and addressed, with appropriate contact details provided. No problems identified</p>
<p>2. Evaluation of the participant information sheet and consent form:</p> <p>Clear and informative; the confidentiality section of the information sheet could perhaps appear on the first page given the potential sensitivity of the material</p>
<p>3. Recommendation:</p> <p>(Please indicate as appropriate and advise on any conditions. If there any conditions, the applicant will be required to resubmit his/her application and this will be sent to the same reviewer).</p> <p><input type="checkbox"/> Approved - no conditions attached</p> <p><input checked="" type="checkbox"/> Approved with minor conditions (no need to resubmit)</p> <p><input type="checkbox"/> Conditional upon the following – please use additional sheets if necessary (please re-submit application)</p> <p><input type="checkbox"/> Rejected for the following reason(s) – please use other side if necessary</p> <p><input type="checkbox"/> Further advice/notes - please use other side if necessary</p>

Name of reviewer: Jacky Knibbs
Signature: Jacky Knibbs
Date: 07/03/11

Appendix D: NHS ethical approval



NRES Committee West Midlands - Solihull

REC Offices
Prospect House
Fishing Line Road
Enfield
Redditch
B97 6EW

Telephone: 01527 582534
Facsimile: 01527 582540

19 May 2011

Miss Helena Young
Trainee Clinical Psychologist
Coventry and Warwickshire Partnership Trust
Room JSG24
Coventry University
Priory Street
Coventry
CV1 5FB

Dear Miss Young

Study title: Experiences of Working in a Crisis Team: Exploring
Emotional Coping using Interpretative
Phenomenological Analysis
REC reference: 11/WM/0126

The Research Ethics Committee reviewed the above application at the meeting held on 11 May 2011. Thank you for attending to discuss the study.

Ethical opinion

1. The committee asked how many staff work in the crisis team. You clarified that the team is approximately 15-20 people. All those in the team will be emailed in the initial recruitment.
2. The committee commented that the debriefing sheet was excellent but that it would be beneficial to also include the information and telephone number on 'What if I feel distressed....' in the information sheet.
3. Consent form – the committee recommended that the last word 'that' in the last point on the consent form '....., **that** the researcher....' be removed to make more sense.
4. The committee asked why personal data was only to be kept for 'less than 3 months'. You explained that the original audio tapes will be destroyed after 3 months but the transcripts will be stored for 5 years.
5. The committee asked for the PALS telephone number to be included on the information sheet as a means of independent advice on research.
6. The committee pointed out that the information sheet referred to Coventry and Warwick REC. This should be amended to West Midlands – Solihull REC.

This Research Ethics Committee is an advisory committee to West Midlands Strategic Health Authority

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Other conditions specified by the REC

1. Include the information and telephone number on 'What if I feel distressed...' as detailed in the debrief sheet in the participant information sheet.
2. Include the PALS telephone number on the participant information sheet as a means of independent advice on research.
3. Amend reference to Coventry and Warwick REC on the information sheet to West Midlands – Solihull REC.
4. Consent form – remove the last word 'that' in the last point on the consent form '....., **that** the researcher....' to make more sense.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for

This Research Ethics Committee is an advisory committee to West Midlands Strategic Health Authority

Appendix E: NHS R&D approval

Coventry and Warwickshire Partnership Trust

West Midlands (South) Comprehensive Local Research Network
Fourth Floor, West Wing (ACF40002)
University Hospitals Coventry & Warwickshire NHS Trust
University Hospital
Clifford Bridge Road
Coventry
CV2 2DX

26th May 2011

Helena Young
Trainee Clinical Psychologist
Coventry and Warwickshire Partnership Trust
Room JSG24, Coventry University
Priory Street
Coventry
CV1 5FB

Dear Helena

Project Title: Experiences of Working in a Crisis Team: Exploring Emotional Coping using Interpretative Phenomenological Analysis
R&D Ref: PAR050411
REC Ref: 11/WM/0126

I am pleased to inform you that the R&D review of the above project is complete, and the project has been formally approved to be undertaken at Coventry and Warwickshire Partnership Trust, within the South Warwickshire Crisis Team. If you wish to extend the project to the North Warwickshire Crisis Team, you must notify R&D prior to commencing research activities. Your research activity is now covered by NHS indemnity as set out in HSG (96) 48, and your trial has been entered onto the Trust's database.

The following documents were reviewed:

Document	Version	Date
NHS R&D Application Form	69275/203836/14/857	
NHS Site Specific Information Form	69275/203842/6/717/86258/210051	Signed 04/04/2011
REC Favourable Opinion Letter		19/05/2011
Protocol	2	24/03/2011
Interview Protocol	1	05/01/2010
Participant Information Sheet	3	25/05/2011
Participant Debrief Sheet	1	06/02/2011
Participant Invitation Email	1	28/03/2011
Consent Form	2	25/05/2011
GP Letter		

Your responsibilities are set out in the attached agreement, which must be signed and returned to the R&D Office. You should keep a copy for your records.

All research must be managed in accordance with the requirements of the Department of Health's Research Governance Framework (RGF) and to ICH-GCP standards. In order to ensure that research is carried out to these standards, the Trust employs the services of an external monitoring organisation to provide assurance. Your study may be randomly selected for audit at any time, and you must co-operate with the auditors.

The duration of Trust approval extends to the date specified in the R&D application form. Action may be taken to suspend Trust approval if the research is not run in accordance with RGF or ICH-GCP standards, or following recommendations from the auditors. Research must commence within two years of the REC approval date and within six months of NHS Permission.

I wish you well with your project. Please do not hesitate to contact me should you need any guidance or assistance.

Yours sincerely



Donna McLean
Assistant RM&G Project Manager

Cc: Dr Michelle Webster, Clinical Psychologist, Coventry and Warwickshire
Partnership Trust
Ian Marshall, Sponsor's Representative, Coventry University

Appendix F: Participant information sheet

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF
WARWICK



PARTICIPANT INFORMATION SHEET

Study Title:

The Emotional Coping of Crisis Team Professionals

What is the purpose of the study?

The purpose of this research study is to explore the emotional experiences and coping styles of clinicians working within a Crisis Resolution team. The research will attempt to understand the range of emotions elicited by Crisis Team working, how they are experienced, the impact they have on clinicians and the coping strategies used to deal with them.

Why have I been invited?

You have been invited to take part because of your experience as a Crisis Team clinician. Exploring and understanding how you make sense of your working experience is the focus of this study.

Do I have to take part?

Participation is voluntary and it is up to you to decide whether you would like to join the study. If you do decide to take part, you will be asked to sign a consent form. The study will be fully explained to you with an opportunity to ask questions before consent is requested.

What will happen to me if I take part?

If you decide to take part you will be invited to attend a research interview. The style of the interview will be conversational in nature in order to explore your experience. The researcher will have some pre-determined questions that they wish to cover to meet the aims of the study. The interview will be recorded using audio equipment and is likely to last about 1 hour. The interviews will be transcribed verbatim and later analysed by the researcher.

Will my taking part in the study be kept confidential?

The audiotapes and interview transcripts in this study will be made anonymous by removing any identifiable information. Consent forms will be stored in a secure, locked cupboard, based at Coventry University to ensure confidentiality.

If you disclose information during the study that either you or another is at risk then the researcher is obligated to follow the Trust Policy of confidentiality.

Data that has been made anonymous may be looked at by the academic supervisor for this project and/or independent researchers. Dr Michelle Webster (Team Psychologist) will be supervising the implementation of this project within the team, however **will NOT have access to your data**. This is to ensure your greater anonymity.

Dean of Faculty of Health and Life Sciences
Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Chair of Department of Psychology
Professor Liz Robinson BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7652 3096

www.coventry.ac.uk

Verbatim quotations that have been made anonymous may be included in the write up of this study. The information you offer during this study will be used for the purpose of this study only. Audiotapes will be securely destroyed following the transcription process. Interview transcripts which have been made anonymous will be stored securely at Coventry University for five years after the study has ended. They then will be destroyed securely.

What is the researcher's role?

The researcher's role within this study is to carry out a research enquiry. It is hoped that participants will find the experience positive. The researcher is unable to offer counselling as part of the research process; the researcher is obliged to maintain the role of researcher within interviews in order to keep themselves and the participant emotionally safe.

What are the possible disadvantages and risks of taking part?

The interviews will focus on how you have experienced working in a Crisis Team from an emotional perspective. There is a possibility that you may become upset by talking about your experience. If at any time during the interview you do not wish to answer particular questions, please tell the researcher, who will then move on.

What if I feel distressed from taking part in the study?

Although the interview is not intended to cause discomfort, as a result of talking about your work you may experience uncomfortable emotions. If these persist after the interview and are a source of concern then you may wish to contact the **Employees Assistance Programme on 0116 2388266**. This is a service that offers face to face confidential counselling to employees who may be experiencing stress associated with work issues, amongst other things.

What are the possible benefits of taking part?

It is hoped that you will experience the interview process as a positive experience, providing you with the opportunity to talk about your experience. The findings from this study will be used to make recommendations on how best to emotionally support clinicians who work in this area, which may be of benefit for you and your colleagues.

What will happen if I don't want to carry on with this study? You can decide to terminate the interviews at any time by informing the researcher. Following your interview you may withdraw your participation up to 1 month after the interview has taken place, by contacting the researcher using the details at the end of this form.

What will happen to the results of the research study?

The results of this study will be submitted for publication to a peer review journal following the completion of the project in May 2012. On completion of the project you will be contacted to see if you wish to receive a summary of the results.

Who is organising and funding the research?

The research is organised by Helena Young who is a doctoral student on the Coventry and Warwick Clinical Psychology Course. This project is not externally funded.

Who has reviewed the study?

This study has been through a University peer review process, approved by Coventry University Ethics Committee, and reviewed and given favourable opinion by West Midlands – Solihull Research Ethics Committee.

If you require independent advice on research you can contact the Patient Advice and Liaison service on: **02476 536804**.

For further information or if you have any issues about how you have been treated during the study, please contact:

Supervisor/Chief Investigator

Dr Adrian Neal (Supervisor)
Helena Young (Chief Investigator)
Doctorate Course in Clinical Psychology
Coventry University
Priory Street
Coventry, CV1 5FB

a.neal@coventry.ac.uk
young2@uni.coventry.ac.uk

Chair of Coventry University Ethics

Professor Ian Marshall
Pro-vice Chancellor (Research)
Coventry University
Priory Street
Coventry, CV1 2UD

i.marshall@coventry.ac.uk

Appendix G: Participant invitation email

Study Title: The Emotional Coping of Crisis Team Professionals

INVITATION

We would like to invite you to take part in a research study. The purpose of this research study is to explore the emotional experiences and coping styles of clinicians working within a Crisis Resolution team.

High levels of stress and burnout have been well documented for mental health clinicians elsewhere. However, due to the recent development of CRHT teams, little is known about how the nature of this type of mental health working impacts on clinicians.

The research will attempt to understand what it is like to work in a Crisis Team from a clinician's perspective. It aims to understand the range of emotions elicited by Crisis Team working, how they are experienced, the impact they have on clinicians and the coping strategies used to deal with them.

An in-depth understanding of the emotional experience of CRHT team clinicians will increase awareness of the needs of staff and inform the development of staff support systems. In turn, this will have a positive impact on the care provided to CRHT team patients.

If you decide to take part you will be invited to attend a confidential research interview. The style of the interview will be conversational in nature in order to explore your experience. The interview will be recorded using audio equipment and is likely to last about 1 hour.

The Participant Information Sheet attached to this email will explain more about this particular research project and what it will involve if you decide to take part.

If you are interested in taking part in this study please reply to this email stating that you are interested. The researcher will then contact you to arrange a time to meet to discuss the project further and conduct an interview if you wish to continue.

Participation is **voluntary** and it is up to you to decide whether you would like to join the study.

If the researcher does not hear from you within two weeks, they will email you once more inviting you to take part. If they do not hear from you two weeks following this, then the researcher will conclude that you do not wish to take part.

Please feel free to contact the researcher if there is anything you would like us to explain further before deciding whether or not to take part.

Thank you for taking the time to read this email.

The Emotional Coping of Crisis Team Professionals
Interview Protocol

Name of Researcher: Helena Young

Bullet points within this protocol represent questions that the researcher may ask to elicit the information needed to meet the aims of the study. They are not intended to be an exhaustive list.

Opening Question

1. Can you tell me about you came to start working in the Crisis Team?
 - How long have you worked in the team / crisis work?
 - Why did you apply to work in the team?

Emotions Experienced

2. Can you tell me about your experiences of working with clients in crisis?
 - How does it make you feel? Why?
 - Can you describe a recent time when you noticed any change in how you were feeling in relation to client work?
 - Thinking about the clients on your case load at the moment what are the types of feelings elicited from working with them?
 - How do you know you are feeling?
 - What do you understand about these emotions?
 - How do you express/show emotions in the room with the client?
 - How do you express/show emotions about clients when not in their presence?
3. How do you experience non-clinical work within the team?
 - How does it make you feel?
 - Can you describe a recent time when you noticed any change in how you were feeling in relation to non-clinical work?
 - Thinking about the non-clinical work that you do, what are the types of feelings elicited from it?
 - How do you know you are feeling?
 - What do you understand about these emotions?
 - How do you express/show emotions regarding non-clinical work at work?

Impact of emotions

4. How does your emotional experience impact you personally?
 - How do you feel about yourself when you have experienced emotions in relation to work?
 - How long do or have these feelings about your work lasted? Do you notice you experience feelings about work when you are not at work?
 - How does your job and feelings elicited from work affect your home life? Relationships outside of work?
 - How do you think your life would be if you worked elsewhere?
5. How does your emotional experience impact you professionally?
 - How do the feelings elicited from work or feelings about your work impact on your:
 - Professional identity?
 - Perceived professional competence?
 - Your ability to do your job?
 - Working relationships with clients and colleagues?
 - Your ability to engage in teamwork?

Management of Emotions

6. How do you respond to your emotions?
 - How do you cope with your feelings?
 - Think of situation when you noticed that an experience at work had elicited emotions within you? What did you do?
 - How is your response helpful?
 - How is your response unhelpful?
 - What resources do you draw on within yourself? At work? At home?
7. What would improve your ability to manage your work related emotions?

Concluding question

8. Is there anything else you would like to add?

Appendix I: Participant consent form

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol



ID number:

CONSENT FORM

Title of project: The Emotional Coping of Crisis Team Professionals

Name of Researcher: Helena Young

Please initial box

- I confirm that I have read and understood the Participant Information Sheet for the above study. I have had the opportunity to consider the information and to ask questions. ☐
- I understand that my participation is voluntary and that I am free to withdraw my data at any time up to 1 month following data collection, when analysis will have begun. ☐
- I give permission for the interview to be recorded using audio equipment. ☐
- I understand that the audio recording of my interview will be transcribed verbatim. I give permission for verbatim quotations that have been made anonymous to be included in the write up of this study. ☐
- I understand that anonymous parts of the data collected during the study may be looked at by the researcher's colleagues (in order to aid analysis) or regulatory authorities and I give permission for this. ☐
- I understand that any information disclosed during the interview that indicates that I or someone else is at risk, the researcher is obligated to follow Trust Policy regarding confidentiality. ☐

Dean of Faculty of Health and Life Sciences
Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805
Chair of Department of Psychology
Professor Liz Robinson BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7652 3096

Please sign and date:

_____ Name of participant	_____ Date	_____ Signature
_____ Name of person taking consent	_____ Date	_____ Signature

Appendix J: Debriefing sheet

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF
WARWICK



PARTICIPANT DEBRIEF SHEET

Version 1 (06.02.11)

Title of study: The Emotional Coping of Crisis Team Professionals

Name of main researcher: Helena Young

Thank you for taking part in our study. Your reflections about your emotional experience of working in a Crisis Team and ways of coping are of great value to us. We would like to thank you for sharing them. We are hoping to use the findings from this study to make recommendations on how best to emotionally support clinicians who work in this area.

Occupational stress in mental health workers is well documented in the literature and is likely to have an affect on the patients being cared for within services. Therefore, the management of stress at work is important for both staff and patients. Emotions at work have been linked to both worker and patient safety within the NHS (Smith et al. (2009). Thus, emotions need to be considered and well managed by leaders to reduce risk at work.

Crisis Resolution Home Treatment (CRHT) teams are a relatively recent addition to mental health service provision in the UK. As a result, little is known about how the nature of these teams impact on the clinicians who work in them (Nelson, Johnson & Bebbington, 2008).

This study aims to explore emotional experiences and coping styles of clinicians working within CRHT teams. It will attempt to find out 'What emotions does the work elicit?', 'How the emotional experience impacts on the clinician?' and 'How clinicians deal with their emotions?'.

An in-depth understanding of the emotional experience of CRHT team clinicians will increase awareness of the needs of staff and inform the development of staff support systems. In turn, this will have a positive impact on the care provided to CRHT team patients.

References

Nelson, T., Johnson, S. & Bebbington, P. (2009) Satisfaction and burnout among staff of crisis resolution, assertive outreach and community mental health teams: A multicentre cross sectional survey. *Social Psychiatry and Psychiatric Epidemiology*, 44, 541-549

Smith, P., Pearson, P. and Ross, F. (2009) Emotions at work: What is the link to patient and staff safety? Implications for nurse managers in the NHS. *Journal of Nursing Management* 17, 230-237

Dean of Faculty of Health and Life Sciences

Dr Linda Meriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Chair of Department of Psychology

Professor Liz Robinson BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7652 3096

www.coventry.ac.uk

What will happen now?

The recording of this meeting will now be transcribed by the lead researcher. Your name and any other information that could link this transcript to you will be removed to ensure your anonymity, and it will be treated confidentially. The research team will read the transcript and make detailed notes about important themes.

What will happen to the results?

The results of this study will be used by the lead researcher, Helena Young, as part of the academic requirements of the Coventry and Warwick Doctoral Course in Clinical Psychology.

A summary of the results will be made available to you and to the Crisis Resolution Home Treatment team. The results of this study will also be put forward for publication in psychology and/or other mental health journals. You will be informed about how you can access the full journal article once published. You will not be personally identified in these reports. Although we may use your words in writing up the research, we will not reveal your identity and we will refer to you by a false name or code.

What if I feel distressed from taking part in the study?

Although the interview was not intended to cause discomfort, as a result of talking about your work you may have experienced uncomfortable emotions. If these persist after the interview and are a source of concern then you may wish to contact the **Employees Assistance Programme on 0116 2388266**. This is a service that offers face to face confidential counselling to employees who may be experiencing stress associated with work issues, amongst other things.

What if I have any questions about the study?

If you have any questions or concerns about this study then please contact the project researcher or supervisor on the details below.

Supervisor/Researcher

Dr Adrian Neal (Supervisor)
Helena Young (Researcher)
Doctorate Course in Clinical Psychology
Coventry University
Priory Street
Coventry, CV1 5FB

a.neal@coventry.ac.uk
young2@uni.coventry.ac.uk

Thank you very much for taking part in this study.

Appendix K: Details of the IPA - analytic process

The analysis within this study followed the six-step approach outlined by Smith et al (2009), which is summarised below.

Step 1: Reading and re-reading

The first stage of analysis involved reading and re-reading the first interview transcript. Engaging with the data in this way promotes the participant as the focus of the analysis and helps the researcher to understand how narratives may link different sections of the interview together.

Step 2: Initial noting

Three types of processes were used in this stage to produce a detailed set of notes on the data:

- Descriptive comments – describing the subject of talk
- Linguistic comments – exploring participant's language
- Conceptual comments – engaging with the data at a conceptual level

Step 3: Developing emergent themes

This stage involved analysing the exploratory comments to identify emergent themes. Emergent themes were produced which aim to capture what is important in the text and are often presented as phrases that are both conceptual and grounded in the data.

Step 4: Searching for connections across emergent themes

This stage involved exploring links between the emergent themes and developing superordinate themes within the transcript. Four types of processes were considered, to aid this process.

- Abstraction – grouping similar emergent themes together
- Subsumption – emergent theme acquires a superordinate status
- Polarisation – examining oppositional relationships between emergent themes
- Function – examining the specific function of themes within the transcript

Step 5: Moving to the next case

Steps 1-4 were then repeated for the other interview transcripts, from the study. Transcripts were viewed individually in an attempt to allow for new themes to emerge.

Step 6: Looking for patterns across cases

This stage involved looking for patterns across transcripts in an attempt to see which themes were most important to the data set as a whole. The most important themes were then reflected as the overarching superordinate themes and the accompanying sub themes for all the data.

Appendix L: Example of coding a transcript using IPA.

Emotions state			
Personal factors	113	in, in the best of moods. I've maybe had a couple of beers the night	Bad form, low mood + beers
Impact decision quality	114	before, you know something like that there then I can go away	= more stress
of decisions	115	feeling a lot more stressed than, and also certainly the impact of my	Pretty crappy decisions
Cumulative effect	116	colleagues as well there's, if I'm on bad form and my colleagues	Try to be non-crappy
of self + colleagues	117	are on bad form you tend to make pretty crappy decisions, so it is,	Take it hard.
mood on decisions	118	no matter how non-crappy you try to make those decisions you do	Additive effect of feeling
	119	end up, you can go away by taking a lot of this, take a lot of the	bad - crap + cap = Crap
	120	work home with you. So you can. Just by virtue there would be	Wake up in night. SLEEP.
	121	more than one occasion that I have woke up in the middle of the	(Worry - alive or hanged
	122	night and sat up and thought I hope Joe Bloggs is still living or I	others
	123	hope so and so Joe Bloggs hasn't killed somebody. So it is. And so	bye audience
Nervous - impacts sleep	124	you can sort of end up lying awake 'til sort of eight o'clock, half	Confirmation made
(decisions)	125	eight the next morning, and ringing work to just to have sort of that	night decision if client
Client's safety confirms	126	yea or nay as to whether I've made the right call, ...and sort of your	OK
correct decisions	127	gut gurgles and all those sort of those physical aspects of stress.	Physical aspects of
	128	My blood pressure will be up at the roof sky high on some	stress
	129	occasions you know. So it is.	mental
	130		
Physical + mental	131	I: So you feel it kind of physically in your body?	
impact of stress	132		
	133	P: yeah, physical, certainly some of the physical aspects of anxiety.	
	134	Also, some of the mental ones and that	
	135		
	136	I: yeah	
Difficulty 'switching	137		
off'	138	P: I find it, I can find it very difficult to switch off at the end of the	Difficult to switch off
	139	shift. Even if it has been a reasonably o.k. shift, I would still find it	'switch off' as if on/off.
	140	particularly difficult you know come sort of ten o'clock or 4 o'clock or	→ separate on/off.
	141	whatever, is the finishing times. And just walking out the doors, it's	work + home.
	142	not like you can just kind of right that's it, works there home life here	Switching off not related
	143	and I sometimes find it really difficult to sort of switch off and then if	to nature of shift.
	144	you end up that you've had a bad shift and you end up staying on.	
	145	Like we had it a week or two ago where we were admitting	"midnight" - depths of the night
Support from 'gracious'	146	somebody at the time we were supposed to be going home. And it	Support from colleague -
colleague	147	was, well it was by the time we'd done it all it was midnight and we	colleagues willing /
	148	were leaving here and my colleague she wasn't on call but she sort	"gracious".
	149	of rather graciously agreed to stay on to help me do the admission.	Physically taking paperwork
Working in home 'time'	150	Ah then I had some paperwork to finish up after that at home. So I	home - PHYSICALLY (MENTAL)
- no choice	151	was physically taking some paperwork home so that I can have it all	Needing to be up loose ends
	152	wrote up and all I'd have to do because it was my day off the next	regardless of time / shift -
	153	day. So I could just drive past and throw it in on my way sort of past	commitment. No choice
	154	and what have you. Some of my other colleagues were able to	I'd have to.
	155	physically input it on my behalf so, it was er.... As I say I do	• work related stuff on
Difficult to relax	156	genuinely sometimes find it very difficult to unwind. And I think that	day off - have life
	157	particular night I think it was about four o'clock in the morning, as it	difficult to unwind
	158	was I was on call anyway so but if anyone had of rang me at four	unwind - wound up
	159	o'clock in the morning then	
	160		
	161	I: & P: both laugh	
	162		
	163	P: then I wouldn't have had too much sleep, so I would have been	
	164	even grumpier than I usually am	
	165		
	166	I: mm, mm	
	167		
	168	P: so it is yeah	